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INTRODUCTION

DRAFT: Introduction to Low Income Health Plan (LIHP) Mental Health Services in Los Angeles County – A Toolkit for Providers

Introduction:

With the implementation of the Low Income Health Plan (LIHP) under the 1115 Waiver, the Department of Mental Health (DMH) joins the Department of Health Services (DHS) in moving closer to true integrated primary care-behavioral health services. Effective July 1, 2011 mental health services will become a mandated component of the LIHP – available to all individuals enrolled in Healthy Way LA (HWLA) who meet mental health medical necessity criteria. Los Angeles County residents between age 19-64 years old, childless or non-custodial parents, whose income is at or below 133% Federal Poverty Level with a valid government issued identification and proof of residence are eligible for enrollment into HWLA.

Although we have worked diligently with our counterparts in DHS to implement the LIHP program, many system changes are necessary in a very short time. This “toolkit” has been prepared to provide you with information and answers to questions we have received from providers. We look forward to continuing our work together as we plan for Health Care Reform in 2014!

Why Deliver Integrated Care? The Business Case for Collaboration

There are many reasons for delivering integrated primary and behavioral health care. Some of the compelling arguments for moving in this direction include:

- Integrated care improves the health outcomes of our population. Those with serious mental illness die (on average) 25 years earlier than the general population; delivering integrated care results in better access to needed primary care and the ability to ensure that treatment interventions (e.g., medication management, laboratory tests) are coordinated, reducing adverse outcomes.
- Integrated care decreases the per capita cost of healthcare. People diagnosed with depression have almost twice the annual health costs of those without the disorder. Treatment of depression reduces not only the disease burden on society, but also the medical costs associated with their health care.
- Integrated care enhances the quality of care provided to clients. Treating mental health conditions impacts care for other disorders (e.g., successful treatment of depression is correlated with reduction in pain for those with co-morbid disorders)

What types of mental health services will be delivered under the HWLA Mental Health Benefit?

Beginning in July 1, 2011, enrollment in HWLA will increase in Los Angeles County and may ultimately reach between 130,000 and 150,000 adults. HWLA primary care services will be delivered through a network that includes DHS directly operated hospitals, comprehensive health centers, and ambulatory care centers in addition to a geographically diverse system of Community Partner agencies.

The HWLA mental health benefit will be delivered through the existing and expanded network of DMH directly operated and contracted specialty mental health clinics. Mental health care may be understood as being delivered in three “tiers” which are delineated in the chart below.

Mental Health Service Delivery under the LIHP

Level of Service	Level of Need	Type of Service
Tier 1	Current priority population: clients with serious mental illness Quadrants* 2 and 4	<ul style="list-style-type: none"> • Full range of rehabilitation option services
Tier 2	Individuals seen in primary care settings who may benefit from short term treatment early intervention Quadrants* 1 and 3	<ul style="list-style-type: none"> • Evidence-based practices • Short Term Treatment • Psychiatric consultation regarding psychotropic medications provided for treating primary care physicians
Tier 3	Individuals seen in primary care settings who receive and desire only medication management Quadrants* 1 and 3	<ul style="list-style-type: none"> • Psychiatric consultation regarding psychotropic medications provided for treating primary care physicians

* Based on the 4 quadrant model from the National Council for Community Behavioral Healthcare

What are the eligibility criteria for HwLA Mental Health Services?

All HwLA enrollees referred for mental health services must meet mental health medical necessity criteria. The specific criteria for each tier of service are listed below.

To be eligible for **Tier 1 services**, an individual must meet the following criteria:

- Be determined to have a serious and persistent mental illness
- Be at serious risk and serious need for mental health care
- Not stable on medications
- Mental health diagnosis such as:
 - Schizophrenia
 - Bipolar disorder
 - Mood disorders
 - Personality disorder with severe impairment
- Severe Functional Impairment
 - Difficulty providing for basic needs
 - Serious Impairment in 2 critical roles (e.g., inability to work, homeless or at risk of losing housing, inability to maintain relationships, significant difficulty parenting, poor self-care)
- Likelihood of need for higher level of care without intervention (e.g, hospitalization, incarceration)

A checklist has been prepared as a guide to determine eligibility for Tier 1 services; it is included in this toolkit.

To be eligible for **Tier 2 services**, an individual must meet the following criteria:

- Be determined to have an acute mental illness
- Be at moderate risk and have a moderate need for mental health care
- Mental health diagnosis such as:
 - Depressive disorder
 - Generalized anxiety disorder
 - Personality disorder with moderate impairment
- Moderate functional impairment
 - Moderate functional impairment in 1-2 roles (difficulty keeping a job, risk of losing housing, unstable relationships, occasional poor grooming or hygiene)
- Ability to benefit from limited focused evidence-based practice

What types of mental health services will be delivered under Tiers 1 and 2?

Clients eligible for Tier 1 mental health services – those with a serious and persistent mental illness – will receive appropriate rehabilitation option mental health services. These services, delivered in one of our network of free-standing specialty mental health agencies, include assessment, individual and group therapy with an emphasis on the recovery model, medication evaluation and management, case management and supported housing, employment and education. Services for individuals with co-occurring substance abuse disorders are also provided.

Clients eligible for Tier 2 mental health services – those with a moderate mental illness – will receive an evidence-based early intervention with demonstrated success in primary care-behavioral health integration. DMH has chosen the Mental Health Integration Program (MHIP), a strategy developed by the University of Washington for implementation. Characteristics of the MHIP model include:

- Collaborative Care Model
- Primary Care Provider (PCP) continues medications as needed
- Stepped interventions
- Therapeutic components
 - Assess symptoms and problems in living
 - Develop targeted treatment plan
 - Problem Solving Therapy
 - Behavioral Activation
 - Assessment of status at each visit
 - Weekly team case consultation with psychiatrist
 - Follow-up between psychiatrist and primary care providers when medications need to be adjusted

Some additional questions regarding Tier 1 and 2 services include the following:

Is medication support an included mental health service for Tier 2 clients?

No. If clients receive early intervention services under Tier 2, they will be offered MHIP, an evidence-based practice. Under this practice, primary care providers will initiate or continue to deliver medication support services. Through HWLA, these medication visits are now eligible for reimbursement under DHS. Although mental health providers may offer consultation regarding complications such as lack of therapeutic response to medication or side effects, responsibility for continuing to prescribe and monitor medications will rest with the primary care provider.

Under what circumstances can clients be transferred from Tier 2 to Tier 1 services?

At any time, if a client receiving Tier 2 services is determined to 1) meet the criteria for Tier 1 services, 2) need the rehab option Tier 1 services and 3) desire a transfer to specialty mental health provider agencies, a referral can be made. Tier 2 providers intending to make such a referral should first use the checklist included in this toolkit to ensure that clients meet the criteria for such a transition. The receiving provider will conduct an assessment to confirm that clients meet the criteria for Tier 1 services and to develop an appropriate treatment plan. Clients should not be automatically transferred for rehab option services simply due to a failure to benefit from Tier 2 services.

Do we expect full integration to be in place on July 1?

While achieving the goal of meaningful and true integration will take some time, we believe the following elements can be introduced immediately:

- Two-way communication between referring provider and mental health clinician
- Co-location of services when possible
- Warm hand-off as appropriate and possible
- Introduction of evidence-based clinical models
- Availability of Tier 1 and Tier 2 services through partnerships established between primary care providers and specialty mental health providers

Using this Toolkit

We believe that the information in this Toolkit will provide you with guidelines for the HWLA mental health services you will deliver. Please note that while some guidelines are relevant for all providers (DMH directly operated agencies, legal entity contract providers, and Community Partners), others are specific to one or two types of providers. Please be sure to note whether a guideline is relevant to your agency; this information will occur at the top of each page.

We look forward to our continued work together as we implement the Low Income Health Plan. If you have questions, please feel free to contact us using the list of DMH staff included in this toolkit.

Thanks so much for your dedication and your support for this effort!

LAC/DMH
HEALTHY WAY LA
PROVIDERS

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. PARTNERSHIPS BETWEEN THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH SERVICES

Community Partner (CP)	SUP DIST	SPA	Tier 2 Service Delivery Site	Tier 1 Partner DMH Directly-operated and/or DMH Contractor	Tier 2 Partner DMH Directly-operated and/or DMH Contractor
Community Partners WITH Mental Health Contract					
AltaMed Health Services	1	7	5427 E. Whittier Boulevard, Suite 101 Los Angeles, CA 90022	ALMA Family Services (C) (<i>Specialty</i> : Spanish language)	Self + ALMA Family Services (C) (<i>Specialty</i> : Spanish language)
Antelope Valley Community Clinic	5	1	45104 10th Street West Lancaster, CA 93534	Mental Health America Los Angeles (C)	Self + Mental Health America Los Angeles (C)
Antelope Valley Community Clinic	5	1	2151 E. Palmdale Boulevard Palmdale, CA 93550	Mental Health America Los Angeles (C)	Self + Mental Health America Los Angeles (C)
Antelope Valley Community Clinic	5	1	45074 10th Street West, Suite 109 Lancaster, CA 93534	Mental Health America Los Angeles (C)	Self + Mental Health America Los Angeles (C)
Asian Pacific Health Care Venture, Inc.	3	4	1530 Hillhurst Avenue Los Angeles, CA 90027	Asian Pacific Counseling and Treatment Center (SSG) (C) (<i>Specialty</i> : Cantonese, Mandarin, Chiu Chow, Taiwanese, Japanese, Khmer, Laotian, Thai, Vietnamese, Tagalog, Spanish and Vietnamese languages)	Self + Asian Pacific Family Center (Pacific Clinics) (C) (<i>Specialty</i> : Cantonese, Mandarin, and Vietnamese languages)
Central City Community Health Center, Inc.	2	6	5970 S. Central Avenue Los Angeles, CA 90001	Kedren Community Health Center (C)	Self
Chinatown Service Center	1	4	767 N. Hill Street, Suite 200 Los Angeles, CA 90012	Special Service for Groups (SSG) (C) (<i>Specialty</i> : Cantonese, Mandarin, Chiu Chow, Taiwanese, Japanese, Khmer, Laotian, Thai, Vietnamese, Tagalog, Spanish and Vietnamese languages)	Self
Clinica Monseñor Oscar Romero	1	4	123 S. Alvarado Street Los Angeles, CA 90057	Institute for Multicultural Counseling and Education Services, Inc. (C) (<i>Specialty</i> : Spanish, Farsi, Russian, Armenian, Hebrew and Arabic languages)	Self + Institute for Multicultural Counseling and Education Services, Inc. (C) (<i>Specialty</i> : Spanish, Farsi, Russian, Armenian, Hebrew and Arabic languages)
Clinica Monseñor Oscar Romero	1	4	Northeast Health Center 2032 Marengo Street Los Angeles, CA 90033	ENKI Health and Research Systems, Inc. (C)	Self + ENKI Health and Research Systems, Inc. (C)
Community Health Alliance of Pasadena	5	3	1855 N. Fair Oaks Avenue Pasadena, CA 91103	Pacific Clinics (C) + Heritage Clinic (C) (<i>Specialty</i> : Older adults and Korean language)	Pacific Clinics (C) + Heritage Clinic (C) (<i>Specialty</i> : Older adults and Korean language)
East Valley Community Health Center, Inc.	1	3	680 Fairplex Drive Pomona, CA 91768	Pacific Clinics (C)	Self
East Valley Community Health Center, Inc.	5	3	420 S. Glendora Avenue West Covina, CA 91790	ENKI Health and Research Systems, Inc. (C)	Self
Eldorado Community Service Center	5	1	2720 E. Palmdale Blvd., #129 Palmdale, CA 93550	Palmdale Mental Health Center (DO)	Self
Eldorado Community Service Center	4	7	21505 Norwalk Boulevard Hawaiian Gardens, CA 90716	Rio Hondo Mental Health Center (DO)	Self
Eldorado Community Service Center	1	7	8207 Whittier Boulevard Pico Rivera, CA 90660	Rio Hondo Mental Health Center (DO)	Self
Eldorado Community Service Center	2	8	4450 W. Century Boulevard Inglewood, CA 90304	West Central Mental Health Center (DO)	Self
Eldorado Community Service Center	2	8	4023 Marine Avenue Lawndale, CA 90260	South Bay Mental Health Center (DO)	Self
El Proyecto del Barrio	3	2	8902 Woodman Avenue Arlington, CA 91331	El Centro de Amistad, Inc. (C) (<i>Specialty</i> : Spanish language)	Self
El Proyecto del Barrio	3	2	Canoga Park 20800 Sherman Way Winnetka, CA 91306	El Centro de Amistad, Inc. (C) (<i>Specialty</i> : Spanish language)	Self
El Proyecto del Barrio	1	3	Azusa Health Center 150 N. Azusa Avenue Azusa, CA 91702	Social Model Recovery Systems, Inc.	Self
Garfield Health Center	1	3	210 N. Garfield Avenue, Suite 203 Monterey Park, CA 91754	Asian Pacific Family Center (Pacific Clinics) (C) (<i>Specialty</i> : Cantonese, Mandarin and Vietnamese languages)	Self
Harbor Community Clinic	4	8	593 W. 6th Street San Pedro, CA 90731	San Pedro Mental Health Center (DO)	Self + San Pedro Mental Health Center (DO)
JWCH Institute, Inc.	2	4	522 S. San Pedro Street Los Angeles, CA 90013	Downtown Mental Health Center (DO)	Self
JWCH Institute, Inc.	2	4	340 N. Madison Los Angeles, CA 90260	Downtown Mental Health Center (DO)	Self
JWCH Institute, Inc.	2	6	3623 Martin Luther King, Jr. Blvd. Lynwood, CA 90262	South Central Health and Rehabilitation Program (SCHARP) (C)	Self
JWCH Institute, Inc.	1	7	6912 Ajax Avenue Bell Gardens, CA 90201	Rio Hondo Mental Health Center (DO)	Self
JWCH Institute, Inc.	4	7	12360 Firestone Boulevard Norwalk, CA 90650	Rio Hondo Mental Health Center (DO)	Self
Mission City Community Network, Inc.	3	2	15206 Parthenia Street North Hills, CA 91343	Hillview Mental Health Center, Inc. (C)	Self
Mission City Community Network, Inc.	3	4	9919 Laurel Canyon Boulevard Pacoima, CA 91331	Hillview Mental Health Center, Inc. (C)	Self
Mission City Community Network, Inc.	3	2	18905 Sherman Way, Suite 200 Reseda, CA 91335	Hillview Mental Health Center, Inc. (C)	Self

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. PARTNERSHIPS BETWEEN THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH SERVICES

Community Partner (CP)	SUP DIST	SPA	Tier 2 Service Delivery Site	Tier 1 Partner DMH Directly-operated and/or DMH Contractor	Tier 2 Partner DMH Directly-operated and/or DMH Contractor
Mission City Community Network, Inc.	3	4	Hollywood 4842 Hollywood Boulevard Los Angeles, CA 90027	TBA	Self
Northeast Community Clinic	1	4	California Family Care Clinic 1414 S. Grand Avenue, 2nd Floor Los Angeles, CA 90015	Amanecer Community Counseling Services (C)	Self
Northeast Community Clinic	1	4	Highland Park 5428 N. Figueroa Street Los Angeles, CA 90042	Amanecer Community Counseling Services (C)	Self
Northeast Community Clinic	2	6	Foshay Middle School 3751 S. Harvard Boulevard Los Angeles, CA 90018	Amanecer Community Counseling Services (C)	Self
Northeast Community Clinic	2	6	Clinica Para Las Mujeres 231 W. Vernon Avenue, Suite 203 Los Angeles, CA 90037	Amanecer Community Counseling Services (C)	Self
Northeast Community Clinic	1	7	Community Medical Alliance 4129 E. Gage Avenue Bell, CA 90201	ENKI Health and Research Systems, Inc. (C)	Self
Northeast Community Clinic	4	8	Wilmington Family Health Care 714 N. Avalon Boulevard, B3 Wilmington, CA 90744	San Pedro Mental Health Center (DO)	Self
Pediatric & Family Medical Center, dba Eisner Pediatric & Family Medical Center	1	4	1500 S. Olive Street Los Angeles, CA 90015	Amanecer Community Counseling Services (C) + ENKI Health and Research Systems, Inc. (C)	Self
South Bay Family Healthcare Center	2	8	742 W. Gardena Boulevard Gardena, CA 90247	Didi Hirsch Psychiatric Services (C)	Self
South Bay Family Healthcare Center	4	8	2114 Artesia Boulevard Redondo Beach, CA 90278	Didi Hirsch Psychiatric Services (C)	Self
South Bay Family Healthcare Center	2	8	1091 S. La Brea Avenue Inglewood, CA 90301	Didi Hirsch Psychiatric Services (C)	Self
St. John's Well Child and Family Center, Inc.	2	6	2115 N. Wilmington Avenue Compton, CA 90222	Kedren Community Health Center (C)	Self
St. John's Well Child and Family Center, Inc.	2	6	Williams 808 West 58th Street Los Angeles, CA 90037	Kedren Community Health Center (C)	Self
St. John's Well Child and Family Center, Inc.	2	6	1910 Magnolia Street Los Angeles, CA 90007	Kedren Community Health Center (C)	Self
Tarzana Treatment Centers	5	1	907 West Lancaster Boulevard Lancaster, CA 93534	Antelope Valley Mental Health Center (DO)	Self
Tarzana Treatment Centers	5	1	422 West Avenue P Palmdale, CA 93551	Antelope Valley Mental Health Center (DO)	Self
Tarzana Treatment Centers	3	2	8330 Reseda Boulevard Northridge, CA 91324	West Valley Mental Health Center (DO)	Self
The Los Angeles Free Clinic, dba The Saban Free Clinic	3	4	8405 Beverly Boulevard Los Angeles, CA 90048	Pacific Clinics-Portals (C)	Self
The Los Angeles Free Clinic, dba The Saban Free Clinic	3	4	Hollywood - Wilshire 5205 Melrose Avenue Los Angeles, CA 90038	Pacific Clinics-Portals (C)	Self
The Los Angeles Free Clinic, dba The Saban Free Clinic	3	4	6043 Hollywood Boulevard Hollywood, CA 90028	Pacific Clinics-Portals (C)	Self
T.H.E. Clinic	2	6	3834 S. Western Avenue Los Angeles, CA 90062	Special Service for Groups (C) (<i>Specialty</i> : Spanish language)	Self
Valley Community Clinic	3	2	6801 Coldwater Canyon Avenue, Suite 1B North Hollywood, CA 91605	San Fernando Valley Community Mental Health Center, Inc. (C)	Self
Venice Family Clinic	3	5	Robert Levine Health Center 905 Venice Boulevard Venice, CA 90291	Didi Hirsch Psychiatric Services (C)	Self
Venice Family Clinic	2	5	Colen Family Health Center 4700 Inglewood Ave, #102 Culver City, CA 90230	Didi Hirsch Psychiatric Services (C)	Self
Venice Family Clinic	3	5	Simms/Mann 2509 Pico Boulevard Santa Monica, CA 90405	Jewish Family Service (C) (<i>Specialty</i> : Older adults who speak Farsi, Russian or Spanish)	Self
Venice Family Clinic	3	5	Venice 604 Rose Avenue Venice, CA 90291	Didi Hirsch Psychiatric Services (C)	Self
Westside Family Health Center	3	5	1711 Ocean Park Boulevard Santa Monica, CA 90405	Didi Hirsch Psychiatric Services (C) + Jewish Family Service (C) (<i>Specialty</i> : Older adults who speak Farsi, Russian or Spanish)	Self + Didi Hirsch Psychiatric Services (C) + Jewish Family Service (C) (<i>Specialty</i> : Older adults who speak Farsi, Russian or Spanish)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. PARTNERSHIPS BETWEEN THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH SERVICES

Community Partner (CP)	SUP DIST	SPA	Tier 2 Service Delivery Site	Tier 1 Partner DMH Directly-operated and/or DMH Contractor	Tier 2 Partner DMH Directly-operated and/or DMH Contractor
Community Partners WITHOUT Mental Health Contract					
All for Health, Health for All, Inc. 519 E. Broadway Glendale, CA 91205	5	2		Didi Hirsch Psychiatric Services (C)	Didi Hirsch Psychiatric Services (C)
American Indian Healing Center 12456 E. Washington Boulevard Whittier, CA 90602	4	7		American Indian Counseling Center (DO)	American Indian Counseling Center (DO)
Arroyo Vista Family Health Foundation 6000 N. Figueroa Street Los Angeles, CA 90042	1	4		Northeast Mental Health Center (DO) + Amanecer Community Counseling Services (C)	Northeast Mental Health Center (DO) + Amanecer Community Counseling Services (C)
BAART Community Healthcare 1111 Market Street, 4th Floor San Francisco, CA 94103	1, 2	3, 4, 6		ENKI Health and Research Systems, Inc. (C) + Kedren Community Mental Health Center (C)	ENKI Health and Research Systems, Inc. (C) + Kedren Community Mental Health Center (C)
Central Neighborhood Medical Group, Inc. 2707 S. Central Avenue Los Angeles, CA 90011	2	6		Barbour and Floyd (C)	Barbour and Floyd (C)
Comprehensive Community Health Center 801 Chevy Chase Drive, Suite 20 Glendale, CA 91205	5, 3	2		Didi Hirsch Psychiatric Services (C)	Didi Hirsch Psychiatric Services (C) + Hillview Mental Health Center, Inc (C)
Compton Central Health Center, Inc. 201 N. Central Avenue Compton, CA 90220	2	6		Barbour and Floyd (C)	Barbour and Floyd (C)
Durfee Family Care Medical Group 2006 Durfee Avenue El Monte, CA 91733	1	3		ENKI Health and Research Systems, Inc. (C)	ENKI Health and Research Systems, Inc. (C)
Emilie Shenouda, MD 10132 California Avenue South Gate, CA 90280	2	6		Kedren Community Mental Health Center (C)	Kedren Community Mental Health Center (C)
Family Healthcare Centers of Greater Los Angeles, Inc 6501 S. Garfield Avenue Bell Gardens, CA 90201	1, 4	7		Bell Gardens - Kedren Community Mental Health Center (C) + Hawaiian Gardens - Special Service for Groups (C)	Bell Gardens - Kedren Community Mental Health Center (C) + Hawaiian Gardens - Special Service for Groups (C)
Korean Health, Education, Information and Research Center 3727 W. 6th Street, Suite 210 Los Angeles, CA 90020	2	4		Special Service for Groups (C) (<i>Specialty</i> : Cantonese, Mandarin, Korean, Spanish and Vietnamese languages) + Amanecer Community Counseling Services (C)	Special Service for Groups (C) (<i>Specialty</i> : Cantonese, Mandarin, Korean, Spanish and Vietnamese languages) + Amanecer Community Counseling Services (C)
KORYO Health Foundation 1058 S. Vermont Avenue Paramount, CA 90723	2	4		Amanecer Community Counseling Services (C)	Amanecer Community Counseling Services (C)
Mission City Community Network, Inc. 831 E. Arrow Highway Pomona, CA 91767	1	3		Prototypes (C)	Prototypes (C)
Northeast Valley Health Corporation 1172 N. Maclay Avenue San Fernando, CA 91340	3, 5	2		San Fernando Valley Community Mental Health Center, Inc. (C) + Santa Clarita Mental Health Center (DO)	San Fernando Valley Community Mental Health Center, Inc. (C) + Santa Clarita Mental Health Center (DO)
Pomona Valley Hospital Medical Center Community Health Center 1798 N. Garey Avenue Pomona, CA 91767	1	3		Prototypes (C)	Prototypes (C)
Queenscare Family Clinic 1300 N. Vermont Avenue, Suite 1002 Los Angeles, CA 90027	1, 2	4, 7		ENKI Health and Research Systems, Inc. (C)	ENKI Health and Research Systems, Inc. (C)
Sacred Heart Family Medical Clinic, Inc. 8540 Alondra Boulevard, Ste. B2 Paramount, CA 90723	4	6		Telecare Corporation (C)	Telecare Corporation (C)
Samuel Dixon Family Health Center, Inc. 25115 W. Avenue Stanford, Ste. A-104 Valencia, CA 91355	5	2		Santa Clarita Mental Health Center (DO)	Santa Clarita Mental Health Center (C)
South Atlantic Medical Group, Inc. 5504 E. Whittier Boulevard Los Angeles, CA 90022	1, 2	3, 7, 8		ENKI Health and Research Systems, Inc. (C)	ENKI Health and Research Systems, Inc. (C)
South Central Family Health Center 4425 S. Central Avenue Los Angeles, CA 90011	2	6		Kedren Community Mental Health Center (C)	Kedren Community Mental Health Center (C)
The Catalyst Foundation for AIDS Awareness and Care 44758 Elm Avenue Lancaster, CA 93534	5	1		Antelope Valley Mental Health Center (DO)	Antelope Valley Mental Health Center (DO)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. PARTNERSHIPS BETWEEN THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH SERVICES

Community Partner (CP)	SUP DIST	SPA	Tier 2 Service Delivery Site	Tier 1 Partner DMH Directly-operated and/or DMH Contractor	Tier 2 Partner DMH Directly-operated and/or DMH Contractor
The Children's Clinic, Serving Children and Their Families 2790 Atlantic Avenue Long Beach, CA 90806	4	8		All Long Beach Sites - Long Beach Mental Health Center (DO) + Pacific Asian Counseling Services (C) (<i>Specialty</i> : Cantonese, Haitian, Khmer, Korean, Japanese, Mandarin, Samoan, Spanish, Tagalog and Thai languages) + Mental Health America Los Angeles (C) (<i>Specialty</i> : Homeless services)	All Long Beach Sites - Long Beach Mental Health Center (DO) + Pacific Asian Counseling Services (C) (<i>Specialty</i> : Cantonese, Haitian, Khmer, Korean, Japanese, Mandarin, Samoan, Spanish, Tagalog and Thai languages) + Mental Health America Los Angeles (C) (<i>Specialty</i> : Homeless services)
The Church of Our Saviour 4368 Santa Anita Avenue El Monte, CA 91731	1	3		ENKI Health and Research Systems, Inc. (C)	ENKI Health and Research Systems, Inc. (C)
Universal Health Foundation 2020 E. First Street Los Angeles, CA 90033	1	4		Telecare Corporation (C)	Telecare Corporation (C)
University Muslim Medical Association, Inc. 711 W. Florence Avenue Los Angeles, CA 90044	2	6		Special Service for Groups (C) (<i>Specialty</i> : Spanish language and co-occurring disorders) + South Central Health and Rehabilitation Program (SCHARP) (C)	Special Service for Groups (C) (<i>Specialty</i> : Spanish language and co-occurring disorders) + South Central Health and Rehabilitation Program (SCHARP) (C)
URDC Human Services Corporation 1460 N. Lake Avenue, Suite 107 Pasadena, CA 91114	5	3		Pacific Clinics (C)	Pacific Clinics (C)
Watts Healthcare Corporation 10300 Compton Avenue Los Angeles, CA 90002	2	6		Augustus F. Hawkins Mental Health Center (DO)	Augustus F. Hawkins Mental Health Center (DO)
Westside Neighborhood Clinic 2125 Santa Fe Avenue Wilmington, CA 90744	4	8		Mental Health America Los Angeles (C)	Mental Health America Los Angeles (C)
Wilmington Community Clinic 1009 N. Avalon Boulevard Wilmington, CA 90744	2, 4	8		San Pedro Mental Health Center (DO)	San Pedro Mental Health Center (DO)
DHS Directly-Operated Programs					
Antelope Valley Health Center 335-B East Avenue K6 Lancaster, CA 93535	5	1		Antelope Valley Mental Health Center (DO)	Antelope Valley Mental Health Center (DO)
Bellflower Health Center 10005 E. Flower Street Bellflower, CA 90706	4	7		Rio Hondo Mental Health Center (DO)	Rio Hondo Mental Health Center (DO)
Dollarhide Health Center 1108 N. Oleander Street Compton, CA 90222	2	6		Compton Mental Health Center (DO)	Compton Mental Health Center (DO)
Edward R. Roybal Comprehensive Health Center 245 S. Fetterly Avenue Los Angeles, CA 90022	1	7		Co-located DMH Program + Rio Hondo Mental Health Center (DO)	Co-located DMH Program + Rio Hondo Mental Health Center (DO)
El Monte Comprehensive Health Center 10953 Ramona Boulevard El Monte, CA 91731	1	3		Co-located DMH Program	Co-located DMH Program
Glendale Health Center 501 N. Glendale Avenue Glendale, CA 91206	5	2		Didi Hirsch Psychiatric Service	Didi Hirsch Psychiatric Service
Harbor-UCLA Family Medicine 1403 W. Lomita Boulevard, Suite 200 Harbor City, CA 90710	2	8		Harbor-UCLA Medical Center	Harbor-UCLA Medical Center
Harbor-UCLA General Medicine 1000 W. Carson Street Torrance, CA 90509	2	8		Harbor-UCLA Medical Center	Harbor-UCLA Medical Center
Harbor-UCLA Ob/Gyn 1000 W. Carson Street, Suite 3B Torrance, CA 90502	2	8		Harbor-UCLA Medical Center	Harbor-UCLA Medical Center
H. Claude Hudson Comprehensive Health Center 2829 S. Grand Avenue Los Angeles, CA 90007	1	6		Co-located DMH Program (Pending) + Kedren Community Mental Health Center (C)	Co-located DMH Program + Kedren Community Mental Health Center (C)
Hi-Desert Multiservice Ambulatory Care Center 44900 N. 6th Street West Lancaster, CA 93536	5	1		Co-located DMH Program + Antelope Valley Mental Health Center (DO)	Co-located DMH Program + Antelope Valley Mental Health Center (DO)
Hubert H. Humphrey Comprehensive Health Center 5850 S. Main Street Los Angeles, CA 90007	2	6		Co-located DMH Program + Augustus F. Hawkins Mental Health Center (DO)	Co-located DMH Program + Augustus F. Hawkins Mental Health Center (DO)
LAC + USC Geriatric Clinic 1200 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Internal Medicine Outpatient, Bldg. 4P61 1200 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. PARTNERSHIPS BETWEEN THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH SERVICES

Community Partner (CP)	SUP DIST	SPA	Tier 2 Service Delivery Site	Tier 1 Partner DMH Directly-operated and/or DMH Contractor	Tier 2 Partner DMH Directly-operated and/or DMH Contractor
LAC + USC Internal Medicine Outpatient, Bldg. 4P81 1200 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Internal Medicine Outpatient, Bldg. 5P61 1200 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Internal Medicine Outpatient, Bldg. 5P81 1200 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Maternal Child AIDS Primary Care 1640 Marengo Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Meds/Pediatrics Continuity Clinic 1100 N. State Street Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
LAC + USC Rand Schrader Primary Care 1300 N. Mission Road Los Angeles, CA 90033	1	4		LAC + USC Outpatient	LAC + USC Outpatient
Lake Los Angeles Community Clinic 16921 East Avenue O, Suite G Lake Los Angeles, CA 93591	5	1		Palmdale Mental Health Center (DO)	Palmdale Mental Health Center (DO)
La Puente Health Center 15930 Central Avenue La Puente, CA 91744	1	3		Arcadia Mental Health Center (DO)	Arcadia Mental Health Center (DO)
Little Rock Community Clinic 8210 Pearlblossom Hwy Little Rock, CA 93543	5	1		Palmdale Mental Health Center (DO)	Palmdale Mental Health Center (DO)
Long Beach Comprehensive Health Center 1333 Chestnut Avenue Long Beach, CA 90813	4	8		Co-located DMH Program	Co-located DMH Program
Mid-Valley Comprehensive Health Center 7515 Van Nuys Boulevard Van Nuys, CA 91405	3	2		Co-located DMH Program (Pending) + West Valley Mental Health Center (DO)	Co-located DMH Program + West Valley Mental Health Center (DO) + Hillview Mental Health Center, Inc (C)
MLK Multiservice Ambulatory Care Center 12021 Wilmington Avenue Los Angeles, CA 90059	2	6		Co-located DMH Program (Pending) + Augustus F. Hawkins (DO)	Co-located DMH Program + Augustus F. Hawkins Mental Health Center (DO)
Olive View-UCLA Primary Care 14445 Olive View Drive Sylmar, CA 91342	3	2		Olive View Urgent Care Center (DO)	Olive View Urgent Care Center (DO)
San Fernando Health Center 1212 Pico Street San Fernando, CA 91340	3	2		San Fernando Mental Health Center (DO)	San Fernando Mental Health Center (DO) + Hillview Mental Health Center, Inc (C)
South Antelope Valley Health Center 38350 40th Street East Palmdale, CA 93552	5	1		Palmdale Mental Health Center (DO)	Palmdale Mental Health Center (DO)
Wilmington Health Center 1325 Broad Avenue Wilmington, CA 90744	4	8		San Pedro Mental Health Center (DO)	San Pedro Mental Health Center (DO)

HEALTHY WAY LA TIER I & II SERVICES

HEALTHY WAY LA SERVICE MATRIX

Level of Need	Client Criteria	Services to be Provided
Tier 1		
<p>Current priority population: individuals with Serious and Persistent Mental Illness (SPMI).</p> <p>High risk and high need for intensive mental health and rehabilitation interventions AND/OR the need for long term services and supports.</p> <p>Individuals with high mental health needs and low to high healthcare needs.</p>	<p>1. An “included” DSM IV TR Diagnosis. (See Attachment “Medi-Cal Included Diagnoses”) AND</p> <p>2. Impairment as a result of the “included” DSM IV TR Diagnosis. At least one of the following must apply:</p> <ul style="list-style-type: none"> significant impairment in an important area of life functioning; e.g., living situation, daily activities, or social support probability of significant deterioration in an important area of life functioning AND typically requires intensive intervention to maintain stability in the community, prevent de-compensation and/or need for a higher level of care (e.g. hospitalization, presentation treatment, etc.). <p>3. May also have problems in maintaining successful community living; such as homelessness, multiple involvements with criminal justice system, multiple emergency room visits.</p>	<p>Clients assessed to determine level of services needed; including: Full Service Partnership (FSP), Field Capable Clinical Services (FCCS), and/or Wellness Center services/interventions.</p> <p>Full Array of Mental Health Services available in the each level of care, including: Assessment, Individual Mental Health Services, Family Support, Group Mental Health Services, Collateral, Medication Support, Targeted Case Management, Case Consultation services, and Peer Support and Self-Help Services as part of the recovery effort.</p>

HEALTHY WAY LA SERVICE MATRIX

Level of Need	Client Criteria	Services to be Provided
Tier 2		
<p>Individuals seen in primary care settings who may benefit from short term, time-limited treatment and early intervention; clients are moderate to low risk and need for mental health interventions; AND/OR</p> <p>Individuals experiencing a recent crisis or trauma, who generally have not been diagnosed with SPMI, but are not at imminent risk of hospitalization nor, in most cases, immediate medication evaluation and services. The assessment should determine if these individuals may be experiencing the onset of a serious psychiatric illness.</p>	<p>Diagnosis:</p> <p>Full range of included diagnoses; generally less severe than Tier 1, AND,</p> <ul style="list-style-type: none"> • Moderate functional impairment, • Difficulty functioning in one or more essential roles AND • Expectation short term early intervention will ameliorate symptoms or life problem. 	<p>M-HIP as the Evidence-Based Practice (EBP) used, with Problem-Solving Therapy (PST) as the therapeutic component.</p> <p>Staff may use other established PEI EBP's, until they are fully trained in PST. These may include: PEI –CORS (AKA: Benjamin Rush, Seeking Safety, and Prolonged Exposure).</p> <p>Procedure Code H 2016 will be used by the Community Partners (CP's) providing HWLA collaborative health/mental health services.</p> <p>Providers will use the Adult Short Assessment form, and completion of needed Progress Notes to comply with IS "Special Program Plan." A single Progress Note completed per "day of contact" up to a maximum of 9 visits will document the CP services.</p> <p>CP's can utilize, where needed, consultation with DMH/LE's consulting psychiatrists and may invoice DMH up to 2 hours per week.</p>

HEALTHY WAY LA SERVICE MATRIX

Level of Need	Client Criteria	Services to be Provided
		<p>Legal Entities (LE) and Directly Operated (DO) programs may utilize the full range of procedure codes available, with the exception of NO Medication Support nor Group Services allowed. Medication support is to be provided by the CP for the Tier 2 population.</p> <p>Under M-HIP, clients will receive up to 6 visits over a 12-week period. A Treatment Authorization Review (TAR) process will be instituted for those needing additional services after the 5th session. The additional number of visits may increase to a total of NINE (9).</p> <p>Additional “Booster” sessions over a 12-month period is under consideration, allowing the case to be kept open at the Medical Home.</p> <p>In some cases, clients in LE’s receiving M-HIP may need to consult with psychiatrist. This consultation may count as one of the allowable 6 visits.</p>

HEALTHY WAY LA SERVICE MATRIX

Level of Need	Client Criteria	Services to be Provided
Tier 3		
<p>Individuals seen in primary care settings who receive and desire only medication management, and have a low need for psycho-therapeutic interventions.</p> <p>May include individuals, previously served in the mental health system, who do not present needing recovery support for a serious mental illness.</p>	<p>Diagnosis:</p> <p>Full range of included diagnoses; generally less severe than Tier 1 or Tier 2; AND</p> <ul style="list-style-type: none"> • Minimal to moderate functional impairment; • Minimal supports to maintain the client's stability and functioning; AND • Expectation that short term early interventions in a health care setting will ameliorate symptoms, presenting life problems and can provide sufficient supportive maintenance. 	<ul style="list-style-type: none"> • Medication prescribed by primary care MD. • Psychiatric consultation, as needed, via telephone, tele-psychiatry, or in-person appointment at mental health clinic.

Attachment

Los Angeles County - Department of Mental Health
Quick Reference check list for TIER I Services - DRAFT

The purpose of this brief checklist is to assist the provider in determining when a client/patient may be appropriate for Tier I Mental Health Services as opposed to TIER II Services. Below are the essential client criteria to consider for Tier I Services. **Please place a check next to each criteria that the client/patient meets:**

1. An "included" DSM IV TR Diagnosis:

Schizophrenia – All 295.XX diagnoses

☐ Schizophrenia

Other Psychotic Disorders

☐ Delusional Disorder

☐ Delusional Disorder Paranoid State

☐ Shared Psychotic Disorder

☐ Unspecified Psychosis

Major Depression and Bipolar Disorder

☐ Major Depression

☐ Bi-Polar Disorders

Other Mood Disorders

☐ Cyclothymic Disorder

Anxiety Disorders

☐ Panic Disorder w/out Agoraphobia

☐ Generalized Anxiety Disorder

☐ Phobic Disorder

☐ Panic Disorder w/Agoraphobia

☐ Social Phobia

☐ Obsessive-Compulsive Disorder

☐ Posttraumatic Stress Disorder

Somatoform Disorders

☐ Conversion Disorder

Dissociative Disorders

☐ Dissociative Amnesia

☐ Dissociative Fugue

☐ Dissociative Identity Disorder

Factitious Disorder

☐ Factitious Disorder with Psychological Signs and Symptoms

2. Functional Impairment as a result of the "included" DSM IV TR Diagnosis. At least one of the following must apply:

☐ Significant impairment in an important area of life functioning; e.g., living situation, daily activities, or social support.

☐ Probability of significant deterioration in an important area of life functioning AND typically requires intensive intervention to maintain stability in the community, prevent de-compensation and/or need for a higher level of care (e.g. hospitalization, presentation treatment, etc.).

3. ☐ May also have problems in maintaining successful community living; such as homelessness, multiple involvements with criminal justice system, multiple emergency room visits.

REFERRAL PROCESS FOR MENTAL HEALTH SERVICES



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APPROVED BY:		ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S)
		DRAFT	

PURPOSE

- 1.1** To describe the process used by the Department of Health Services (DHS) providers to facilitate non-emergency referrals of current enrollees of Healthy Way LA (HWLA) to the Department of Mental Health (DMH)'s network of care for specialty mental health services.

DEFINITIONS

DHS Provider: A DHS provider, for the purpose of this policy, refers to a DHS physician, nurse practitioner, or physician assistant working in a DHS clinic (directly-operated or contracted ambulatory care clinic or directly-operated hospital out patient clinic) **where there are no DMH co-located staff on premises.**

Non-emergency: A non-emergency refers to a routine psychiatric referral in which the patient does not pose an imminent risk of suicide, homicide or is gravely disabled due to a mental illness, and therefore unable to care for their basic needs such as food, clothing and shelter.

POLICY

- 2.1** All HWLA clients will be provided with an initial appointment for specialty mental health services within **thirty (30) business days** of the DHS request.
- 2.2** All HWLA referrals from DHS providers for specialty mental health services must be accompanied by a DMH-approved referral form (See Attachment I, Department of Mental Health Referral).



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- 2.3** DMH and DHS have agreed to facilitate and track all HWLA referrals for specialty mental health services in the manner described in Policy # XX, Coordination of HWLA Referrals for DMH Specialty Mental Health Services.
- 2.4** DHS will ensure that HWLA enrollees are given the 24-hour DMH Access Line (800-854-7771) for enrollees wishing to self-refer directly to DMH for a specialty mental health services provider in their area.

PROCESS

- 3.1** DHS providers will complete the Department of Mental Health Referral form.
- 3.1.1** Whenever possible, copies of a recently administered screening tool, e.g. Patient Health Questionnaire (PHQ) 2, 4, or 9 (Attachments II, III, and IV) should accompany the DHS referral to DMH; and
- 3.1.2** Verify the client is currently enrolled in HWLA.
- 3.2** Upon completion of referral form, DHS providers are to promptly notify the HWLA Care Coordinator at their facility that a referral for specialty mental health services has been completed.
- 3.3** Upon receipt of the referral, HWLA Care Coordinators are to:
- 3.3.1** Fax the referral and any accompanying documents to the DMH Service Area Navigator within **three (3) business days** of receipt of referral.
- 3.3.2** A DMH Service Area directory (Attachment V) will be provided to DHS administration for distribution to DHS providers.



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- 3.4** The DMH SA Navigator, upon receipt of the Department of Mental Health Referral form, will notify the HWLA client within **three (3) business days** to provide them with the contact information of the DMH provider to which they are being referred and the appointment date.

ATTACHMENTS

- Attachment I Department of Mental Health Referral Form
- Attachment II Patient Health Questionnaire (PHQ) 2
- Attachment III Patient Health Questionnaire (PHQ) 4
- Attachment IV Patient Health Questionnaire (PHQ) 9
- Attachment V DMH list of SA Navigation Teams and Contact Information

DEPARTMENT OF MENTAL HEALTH REFERRAL
FROM DEPARTMENT OF HEALTH SERVICES

PATIENT INFORMATION

PROGRAM:

☐ SPD

☐ HWLA - ID#:

☐ Other:

Name:

DOB:

Address:

Phone Number:

Preferred Language:

Special Needs (Wheelchair, Translator, Hearing, Sight):

Medical Diagnosis(es):

Psychiatric Diagnosis(es) (if known):

Name of Screening Tool (Indicate which screening tool used and attach to Referral Form)	Score (if previously administered)	Date of Administration
<input type="checkbox"/> PHQ 2 <input type="checkbox"/> PHQ 4 <input type="checkbox"/> PHQ 9		
<input type="checkbox"/> Other:		

Current Medication(s) (if available, attach print out of current medications):

Date Primary Care Provider discussed referral with Patient:

Reason for Referral to Mental Health:

- ☐ Depression symptoms but not suicidal, homicidal, or gravely disabled
("Gravely Disabled" – unable to provide for his or her basic needs for food, clothing or shelter due to a mental disorder)
- ☐ Anxiety symptoms
- ☐ Social stressors
- ☐ Mood symptoms related to medical diagnosis(es)
- ☐ Other (please explain below)

Referring Provider Information

Name of Referring Clinic:

Print Name & Title of Referring Provider:

Signature:

Date:

Time:

Medical Home Team Member Name & Title:

Contact Number:

Fax Number:

DMH USE ONLY

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Name:

IS#:

Agency:

Provider #:

DHS USE ONLY

DHS Referring Provider:

- ☐ Patient previously presented by "warm hand-off" to on-site DMH staff (Co-Location) on _____ (date).

Patient Identification

DEPARTMENT OF MENTAL HEALTH REFERRAL FORM from HEALTHCARE PROVIDERS

Purpose: This form is for the use of Primary Care Providers (PCP) when making referrals of non-emergency clients to the Department of Mental Health.

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use “✓” to indicate your answer)

Not
at all

Several
days

More than
half the
days

Nearly
every day

1. Feeling nervous, anxious or on edge

0

1

2

3

2. Not being able to stop or control worrying

0

1

2

3

3. Little interest or pleasure in doing things

0

1

2

3

4. Feeling down, depressed, or hopeless

0

1

2

3

(For office coding: Total Score T_____ = _____ + _____ + _____)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your
work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
---	---	---	--



DEPARTMENT OF MENTAL HEALTH

Specialty Mental Health Services for Healthy Way LA (HWLA) Enrollees

6/27/2011

Listing of the HWLA Service Area (SA) Navigation Team Leaders for DMH

Service Area	Team Leader Name	Contact Phone Number	Address	Fax Number	E-Mail
1	Miesha Worthey	(661) 223-3843	2323 A East Palmdale Blvd. Palmdale, CA 93550	(661) 575-9005	MWorthey@dmh.lacounty.gov
2	Darrell Scholte	(818) 610-6744	6800 Owensmouth Ave., #160 Canoga Park, CA 91303	(818) 348-8977	DScholte@dmh.lacounty.gov
3	Eugene Marquez	(626) 471-6545	301 E Foothill Blvd. Arcadia, CA 91006	(626) 471-3573	EMarquez@dmh.lacounty.gov
4	Christie Hubbard	(323) 671-2638	5000 W. Sunset Blvd., Suite 600 Los Angeles, CA 90027	(323) 913-9456	CHubbard@dmh.lacounty.gov
5	Joseph "Sandy" Mills	(310) 482-6619	11303 W. Washington Blvd., Suite 200 Los Angeles, CA 90066	(310) 313-3096	JMills@dmh.lacounty.gov
6	Margarita Cabrera	(323) 290-5829	3751 Stocker Street Los Angeles, CA 90008	(323) 290-3240	MCabrera@dmh.lacounty.gov
7	Terelui "Tere" Antoni	(213) 351-5089	550 S. Vermont, 3rd Floor Los Angeles, CA 90020	(213) 380 -2971	TAntoni@dmh.lacounty.gov
8	Alicia "Lisa" Powell	(562) 435-2297	100 W. Oceangate, Suite 550 Long Beach, CA 90802	(562) 432-0612	APowell@dmh.lacounty.gov



DEPARTMENT OF MENTAL HEALTH
Operational Manual
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SUBJECT Referral Response Process for Healthy Way L.A. (HWLA) Enrollees	POLICY NO. XX	EFFECTIVE DATE DRAFT	PAGE 1 of 2
APPROVED BY:		ORIGINAL ISSUE DATE DRAFT	DISTRIBUTION LEVEL(S) DMH and DHS

PURPOSE

- 1.1 To describe the process used by Department of Mental Health (DMH) providers to facilitate referral responses of non-emergency clients to Department of Health Services (DHS) providers.

DEFINITIONS

DHS Provider: A DHS provider, for the purpose of this policy, refers to a DHS physician, nurse practitioner, or physician assistant working in a DHS facility, directly-operated, or contracted hospital or ambulatory care clinic, or who works in a DHS outpatient setting where there are no DMH co-located staff on premises.

Non-emergency: A non-emergency refers to a routine psychiatric referral in which the patient does not pose an imminent risk of suicide, homicide, or is gravely disabled due to a mental illness, and therefore, unable to care for their basic needs such as food, clothing, and shelter.

POLICY

- 2.1 All DMH providers that have evaluated a HWLA enrollee are required to provide a response back to the DHS referring provider using the Department of Mental Health Referral Response for HWLA Enrollee form #XX

PROCESS

- 3.1 DMH providers will complete the Department of Mental Health Referral Response for HWLA Enrollee form.



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- 3.1.1** Following completion of the initial evaluation, DMH providers shall complete a Department of Mental Health Referral Response for HWLA Enrollees form (Attachment I). The original Referral Response form shall be given to the DHS provider while a copy of the form is retained in the DMH Clinical Record.
- 3.1.2** The Referral Response form shall be completed and returned to the DHS provider as promptly as possible following DMH initiating services with the referred individual.
- 3.1.2.1** In addition to providing a response to the DHS provider following the first visit, updates will be provided to the DHS provider whenever clinically significant changes occur using the Referral Response for HWLA Enrollee form (Attachment I).
- 3.1.2.2** Upon discharge of the client from mental health services, a DMH Discharge Summary form, MH 517 (Attachment II), will be sent to the DHS referring provider.
- 3.1.3** In cases where the referred individual declines DMH services, is inappropriate for specialty mental health services, or when DMH is unable to contact the enrollee, a Referral Response form containing this information shall be provided as promptly as possible following such determination.

Attachment I: Department of Mental Health Referral Response for Healthy Way L.A. (HWLA) Enrollees

Attachment II: DMH Discharge Summary form, MH 517

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE

For a Healthy Way L.A. Referral, provide the HWLA ID#:

Client Information

MRUN: _____

Name: _____ DOB: _____

Address: _____ Phone Number: _____

Referring Physician and Care Coordinator Information

Referring Physician: _____

Name of Clinic: _____

Care Coordinator Name & Title: _____

Phone Number: _____ Fax Number: _____

DMH Disposition

- | | |
|---|---|
| <p><input type="checkbox"/> Individual accepted for services</p> <p><input type="checkbox"/> Individual declined DMH services</p> <p><input type="checkbox"/> Unable to contact individual</p> | <p><input type="checkbox"/> DMH services not indicated <i>(If selecting this box, please be sure to include in General Findings the reason DMH services are not indicated at this time, along with any recommended linkage information.)</i></p> |
|---|---|

General Findings (include additional areas of identified need):

Mental Health Diagnosis(es):

Psychotropic medications prescribed by DMH:

Treatment Plan Overview (include planned treatment interventions; if barriers or complications are a focus of concern include below):

Service Area Navigator Information

DMH SA Navigator: _____

Phone Number: _____ Fax Number: _____

Responding Provider Information

Print Name & Title of Responding Provider: _____

Signature: _____ Date: _____ Time: _____

Name of DMH Clinic: _____ Telephone #: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

IS#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

DMH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Original Copy – To Agency Initiating Referral

NCR Copy – Retained by DMH Program

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Purpose: This form is for the use of DMH Staff when responding to referrals of non-emergency clients by Primary Care Providers (PCP).

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

DISCHARGE SUMMARY

Admission Date: _____

Discharge Date*: _____

Presenting Information:

Services Received and Response:

Medication(s): (Include Dosage & Response) ☐ None

Disposition and Recommendations: (If referred, include name of agency(s) or practitioner(s))

Referral Out Code _____

Diagnosis: (check one)

Axis I ☐ Prin / Sec _____ Code _____

☐ Prin / Sec _____ Code _____

Axis II ☐ Prin / Sec _____ Code _____

Axis III ☐ _____ Code _____

Axis V ☐ Discharge GAF _____ Prognosis _____

Signature & Discipline

Date

Reviewer's Signature & Discipline

Date

*Discharge Date: last service date or last cancelled or missed appointment.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Name: _____

MIS #: _____

Agency: _____

Prov. #: _____

Los Angeles County - Department of Mental Health

DISCHARGE SUMMARY

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

Subject	Policy No.	Effective Date	Page
		Revision Date	DISTRIBUTION LEVELS
MHIP – Clinical Consultation with Psychiatrist			1 of 1 CPs and LEs

PURPOSE

To provide direction and information surrounding clinical consultation with a psychiatrist for clients being treated under the Mental Health Integration Program (MHIP) model by Primary Care Providers (PCP).

DEFINITION

PCP, for the purpose of this policy, may be physicians, nurse practitioners or physician assistants.

POLICY

Clinical consultation with the MHIP team psychiatrist may be provided to the PCP in situations where the client has been non-responsive to treatment. Situations prompting such requests may be one or more of the following:

1. PCP is prescribing psychotropic medications, usually anti-depressant or anxiolytic medications, and the client has not had an improvement in symptoms within the anticipated time frame.
2. PCP recognizes the need to prescribe psychotropic medications but is uncertain regarding the best choice of medications for the particular symptom profile associated with a client.
3. Client symptoms are not improving or are worsening based on session-by-session scores on the screening tools (PHQ-9 or GAD-7 or PCL-PC).
4. Client is reporting acute distress or disorganization consistent with serious risk factors, such as suicidality, homicidality or grave disability.

Psychiatric consultation by the MHIP team psychiatrist with a client is directly reimbursable and will be counted as one session toward the maximum number of allowed sessions for those clients receiving MHIP services.

PROCEDURES

The PCP or the Care Manager may request that the MHIP Team psychiatrist conduct a face-to-face consultation with client.

The mechanism for arranging consultation will be based upon specific processes determined by the MHIP team.

HEALTHY WAY LA MENTAL HEALTH SERVICES

DRAFT

GUIDELINES FOR REFERRALS TO SPECIALIZED LANGUAGE PROVIDERS AND PROVIDERS OF SERVICES TO OLDER ADULTS

PURPOSE

To provide guidelines for referrals to HWLA specialized language providers and providers of services to older adults.

GUIDELINES

- 1.1 Primary care providers that identify a need for mental health services to be delivered in a client's primary language or language of choice or by providers with expertise in the delivery of services to older adults should note this preference on their HWLA mental health referral form.
- 1.2 Service Area navigators will review HWLA mental health referral forms to determine whether clients referred have a need for mental health services to be provided in specific languages or by providers with expertise in delivery of services to older adults.
- 1.3 Service Area navigators will link HWLA mental health clients with those linguistically-appropriate or age-specific providers in closest proximity to the clients' homes. Such providers may be drawn from the list of specialty providers (see attached) that may be independent of the pairing of primary health care agencies with DMH legal entity or directly operated programs.
- 1.4 Should HWLA mental health clients require American Sign Language interpreters, mental health providers will utilize the existing countywide agreement for the provision of ASL translation services.



DEPARTMENT OF MENTAL HEALTH
Operational Manual
Specialty Mental Health Services
for Healthy Way LA (HWLA) Enrollees

SUBJECT Coordination of HWLA Referrals for DMH Specialty Mental Health Services	POLICY NO. XX	EFFECTIVE DATE DRAFT	PAGE 1 of 4
APPROVED BY:		ORIGINAL ISSUE DATE DRAFT	DISTRIBUTION LEVEL(S) DMH and DHS

PURPOSE

- 1.1** To define the process by which referrals from the Department of Health Services (DHS) to the Department of Mental Health (DMH) for Healthy Way LA (HWLA) enrollees requiring DMH specialty mental health services will be coordinated.

DEFINITIONS

HWLA Care Coordinator: HWLA Care Coordinators are defined as individuals who can provide the full range of care coordination for individuals requiring linkage to necessary services including specialty mental health services to ensure access and continuity of care.

DMH Service Area (SA) Navigator: DMH SA Navigators are defined as individuals who can assist HWLA enrollees in accessing mental health services. Further, DMH SA Navigators facilitate linkage and communication with community-based organizations and providers to strengthen the array and quality of available services.

POLICY

- 2.1** In order to ensure that referrals are provided to specialty mental health services in a timely manner, DMH and DHS agree to coordinate the tracking of referrals.
- 2.2** DMH and DHS have designated key staff members to assume responsibility for the communication and coordination of referrals for specialty mental health services.



DEPARTMENT OF MENTAL HEALTH
Operational Manual
Specialty Mental Health Services
for Healthy Way LA (HWLA) Enrollees

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
Coordination of HWLA Referrals for DMH Specialty Mental Health Services		DRAFT	2 of 4

- 2.3** All HWLA clients will be provided with an initial appointment for specialty mental health services within **thirty (30) business days** of the DHS request.

PROCEDURE

- 3.1** The HWLA referral process and tracking of the HWLA referrals will be coordinated through the DMH Service Area Navigator and the HWLA Care Coordinator. Their respective roles and responsibilities are outlined below.

- 3.2** Role and Responsibilities of the DMH Service Area Navigator:

- 3.2.1** Receive the referral form from the HWLA Care Coordinator:

- 3.2.1.1** If the information contained on the Department of Mental Health Referral form is either incomplete or inaccurate then both the DMH SA Navigator and the HWLA Care Coordinator will take steps to resolve the matter so that the HWLA referral may be completed. In situations where the DMH SA Navigator is unable to resolve referral issues then they will consult with their Service Area District Chief or designee.

- 3.2.1.1.1** Any unresolved issues that prevent completion of the referral may be handled through an appeal and dispute resolution process as outlined in **Policy # XX**.

- 3.2.2** Identify an appropriate mental health provider either within the immediate service area or another service area in close proximity to the member's residence;

- 3.2.3** Contact the identified provider within **three (3) business days** of receiving the referral from the HWLA Care Coordinator;

- 3.2.4** Complete and maintain the tracking tool (Attachment I);

- 3.2.5** Facilitate weekly contacts with the HWLA Care Coordinator(s) to reconcile the referral list;



DEPARTMENT OF MENTAL HEALTH
Operational Manual
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for Healthy Way LA (HWLA) Enrollees

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- 3.2.6 Facilitate weekly contacts with the HWLA Care Coordinator(s) to reconcile the DMH Response to Primary Care Provider forms;
- 3.2.7 Identify any system issues that interfere with the referral process;
- 3.2.8 Report any issues to their supervisor that require direction from management; and
- 3.2.9 Provide weekly reports on the initial scheduled appointment dates for each HWLA referral to the HWLA Care Coordinator.

3.3

Role and Responsibilities of the HWLA Care Coordinator:

- 3.3.1 Provide a copy of the referral form and the completed Patient Health Questionnaire (PHQ) 4 or PHQ 9 form used to assess the individual to the DMH Service Area Navigator within **three (3) business days** of receipt of the referral from the DHS Provider;

3.3.1.1 If the information contained on the Department of Mental Health Referral form is either incomplete or inaccurate then both the DMH SA Navigator and the HWLA Care Coordinator will take steps to resolve the matter so that the HWLA referral may be completed. In situations where the HWLA Care Coordinator is unable to resolve referral issues then they will consult with their Service Area District Chief or designee.

3.3.1.1.1 Any unresolved issues that prevent completion of the referral may be handled through an appeal and dispute resolution process as outlined in **Policy # XX**

- 3.3.2 Participate in weekly scheduled contacts with the DMH Service Area Navigator to reconcile the referral list;
- 3.3.3 Participate in weekly scheduled contacts with the DMH Service Area Navigator to reconcile the DMH Response to PCP forms;
- 3.3.4 Identify any system issues that interfere with the referral process; and



DEPARTMENT OF MENTAL HEALTH
Operational Manual
Specialty Mental Health Services
for Healthy Way LA (HWLA) Enrollees

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
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3.3.5 Report to their supervisor any issues that require direction from management.

3.4 Establish a Tracking Tool for Referrals to DMH (Attachment I). The DMH Service Area Navigator and HWLA Care Coordinator will maintain a log of all referrals that include at a minimum:

3.4.1 Date of referral from DHS staff to HWLA Care Coordinator. [Must be completed within **one (1) business day**];

3.4.2 Date of referral from HWLA Care Coordinator to DMH Service Area Navigator. [Must be completed within **three (3) business days from the initial date of referral**];

3.4.3 Date of referral from DMH Service Area Navigator to mental health provider. [Must be completed within **three (3) business days**];

3.4.4 Name of mental health provider receiving referral;

3.4.5 Date of mental health appointment. Specialty care access must be provided within **thirty (30) business days** of request of DHS Provider;

3.4.6 Date DMH forwarded completed copy of DMH Response to Primary Care Provider Form.

ATTACHMENT I Tracking Tool for HWLA Referrals to DMH

TRACKING OF HWLA REFERRALS

General Guideline:

The Medicaid 1115(a) waiver requires access to specialty services be provided at minimum within 30 business days of the request for services. All referrals to specialty mental health services must be tracked and referral tracking reports using and excel file format must be submitted to DMH administration on a monthly basis.

An electronic referral tracking application is under development and will be made available to providers so that all providers will have the ability to enter tracking referral data directly into a DMH systems, thus eliminating the need to submit monthly reports in excel format.

Referral Tracking Components:

The essential tracking elements contained in the excel file format are listed below along with directions for completion:

- Column A: Enter client HWLA ID number
- Column B: Enter client name
- Column C: Enter client age
- Column D: Enter client gender. See drop down menu with gender selections contained in IS Codes Manual.
- Column E: Enter client preferred language. See drop down box for selecting language based on languages contained in the IS Codes Manual.
- Column F: Enter client ethnicity. See drop down box for selecting ethnicity based on ethnicities contained in IS codes manual.
- Column G: Enter presenting problem. See drop down box with major categories of presenting problems.
- Column H: Enter date of warm hand-off, if applicable.
- Column I: Enter date of referral. This date is either the date of the referral from the PCP or is the date that the HWLA member requests mental health services.
- Column J: Enter date of Initial Appointment
- Column K: Do not enter data into this field. This field will be auto calculated by DMH staff for the days between the referral and initial appointment.
- Column L: Enter Status of referral. See drop down box that contains major categories regarding the status of the referral.

Data Collection Requirements

Community Partner (CP) Agencies:

1. All Tier 2 services must be tracked with all the essential tracking elements completed in the excel worksheet.

2. Submit excel file **without HWLA ID or client name** (Protected Health Information – PHI) to DMH on the 15th day of the following month via e-mail to: Mr. Robert Wu at rwu@dmh.lacounty.gov. (For example, all information tracked for referrals in July is submitted no later than August 15th.)
3. If PCP believes the client is in need of services beyond the level of a Tier II, referral should be directed to the applicable DMH partner agency that is providing Tier 1 services. Referral information will be forwarded to the accepting DMH agency who will then assume responsibility for tracking.

Legal Entity (LE) Providers

1. LE providers partnering with a DHS CP or DHS directly-operated program for the delivery of Tier 2 services, must track all referrals for mental health services with all the essential tracking elements completed in the excel worksheet.
2. Submit excel file **without HWLA ID or client name** (Protected Health Information – PHI) to DMH on the 15th day of the following month via e-mail to: Mr. Robert Wu at rwu@dmh.lacounty.gov. (For example, all information tracked for referrals in July is submitted no later than August 15th.)

DMH Directly-Operated (DO) Programs

1. All HWLA enrollee initial appointments for mental health services regardless of Tier, must be tracked as part of the referral process.
2. DMH DO. will contact the Service Area (SA) navigator in their area and relay the information to the SA navigator who will then enter the information in the referral tracking log system. If the computerized tracking application is not complete on July 1, 2011, all SA navigators will be required to track referrals in an excel file format as described above. The excel referral tracking system will be made available on a DMH *shared drive* for entering information across the SA.
3. DMH programs that have an agreement to accept referrals from a DHS directly-operated health center will be responsible to track these referrals and provide the necessary information to the SA navigator for entry into the referral tracking system.

DMH Access Center

1. For clients self-referring through the Access Center, Access will initiate contact with the SA navigator closest to the client's residence. The SA navigator will then assume responsibility for facilitating appointments and tracking of these referrals in the manner described above. Please reference DMH Directly-Operated Programs #2.

DMH/DHS Collaboration Programs

1. In most instances, where DMH staff are stationed on a full-time basis in a DHS health center, the DMH/DHS Collaboration staff will receive and track all referrals.
2. In situations where the DMH/DHS Collaboration staff are unable to accept additional referrals from the PCP, the DHS Health center will be directed to contact the partnering DMH agency to accept the referrals. In such situations, the DMH partnering agency will then assume responsibility for tracking the referral in conjunction with the SA navigator.

Attachments:

Referral Tracking Log

Drop down menu

IS Codes Manual: Gender, Preferred Language, Ethnicity

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH INTEGRATION PROGRAM
REFERRAL TRACKING FORM**

Provider Name: _____
 Provider Number: _____
 Month of Service: July 2011

If a Warm Hand Off, date of referral should be the date of Warm Hand Off. If no warm hand off mark with N/A.

** If no initial appt., type in "See Status" and provide explanation in Status section.*

Do Not Complete

	A	B	C	D	E	F	G	H	I	J	K	L
#	HWLA ID	Client Name	Age	Gender	Preferred Language	Ethnicity	Presenting Problem	Date of Warm Hand Off	Date of Referral	Date of Initial Appt. *	Days (between Referral & Initial Appt.)	Status
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH INTEGRATION PROGRAM
REFERRAL TRACKING FORM
DROP DOWN MENU**

(I). Presenting Problem

1. Depression
2. Anxiety
3. Both depressive and anxiety symptoms
4. Psychosocial or environmental stressors
5. Traumatic Experience
6. Mood symptoms related to medical diagnosis
7. Grief and loss issues
8. DTS/DTO/GD
9. Substance abuse problems
10. Psychosis
11. Other (Please Specify)

(II). Status

1. Individual accepted for services
2. Individual declined DMH services
3. Declined DMH services due to co-pay
4. Client did not show
5. Unable to contact individual
6. Individual does not meet program criteria; no referral indicated
7. Individual does not meet program criteria; referral to community based services (substance abuse resources, support groups, etc)
8. Individual does not meet program criteria; referred for outpatient mental health services
9. Individual does not meet program criteria due to DTS/DTO/GD; DHS to handle emergency
10. Individual ineligible for services (IHSS, Parolee, Medicare Managed Care)
11. Client referred out due to language need not available through program
12. Rescheduled for future appointment
13. Other (Please Explain)

GENDER

<u>Codes</u>	<u>Description</u>
M	Male
F	Female
O	Other – Includes gender changes, undetermined gender and live birth with congenital abnormalities which obscure gender identification.
U	Unknown/Not Reported – Indicates that the gender of the client was not available.

LANGUAGES

<u>Code</u>	<u>Language</u>	<u>Code</u>	<u>Language</u>	<u>Code</u>	<u>Language</u>
19	Afghan, Pashto, Pusho	40	Hungarian	59	Romanian
20	Afrikaans			60	Russian
17	American Sign	41	Ibonese		
21	Arabic	42	Igorot		
18	Armenian	43	Italian	10	Samoan
		44	Ilocano or Iloko	61	Serbo-Croatian
23	Bengali	45	Ilongot	62	Singhalese
24	Bulgarian			02	Spanish
25	Burman or Burmese	08	Japanese	63	Swahili
				04	Swatowese
26	Calo	46	Konkani	64	Swedish
27	Cambodian	09	Korean		
06	Cantonese			11	Tagalog (see Filipino)
28	Cebuano	47	Lao	65	Taiwanese
07	Chinese, other	48	Lingala or Ngala	66	Telegu
29	Choctaw	49	Lithuanian	67	Thai
30	Creole			05	Toisan
31	Czech	03	Mandarin	68	Tonga
		50	Marathi	69	Turkish or Ottoman
32	Danish	36	Mien		
33	Dutch			71	Ukranian
		51	Norwegian	70	Urdu
01	English				
34	Ethiopian	54	Other Sign	12	Vietnamese
		75	Other Non-English	72	Visayan
22	Farsi				
15	French	52	Pakistani	73	Yao
11	Filipino, Tagalog	53	Pangasinan	14	Yiddish
		56	Polish	74	Yoruba
16	German	57	Portuguese		
35	Greek	58	Punjabi	98	Unknown/Not Reported
				99	Other
13	Hebrew				
37	Hindi				
38	Hindustani				
39	Hmong				

ETHNICITY CODES

<u>Code</u>	<u>Ethnicity Description</u>																																				
01	White																																				
02	Black																																				
03	Hispanic – Indicate ethnic background or region of origin: <ul style="list-style-type: none">• Mexico• Central America• South America• Cuba• Puerto Rico• Other																																				
04	American Indian or Alaska Native - Specify tribe from the list below: <table><tr><td>Assiniboine</td><td>Hoopa</td><td>Mono</td><td>Sioux</td></tr><tr><td>Apache</td><td>Juaneno</td><td>Navajo</td><td>Smith River</td></tr><tr><td>Blackfeet</td><td>Kumeyaay</td><td>Paiute</td><td>Tohono O'Odham</td></tr><tr><td>Cahuilla</td><td>Karuk</td><td>Pima</td><td>Tolowa</td></tr><tr><td>Cherokee</td><td>Luiseno</td><td>Pit River</td><td>Wintun</td></tr><tr><td>Choctaw</td><td>Maidu</td><td>Pomo</td><td>Yaqui</td></tr><tr><td>Chumash</td><td>MeWuk</td><td>Pueblo</td><td>Yokut</td></tr><tr><td>Dieguneno</td><td>Mission</td><td>Serreno</td><td>Yurok</td></tr><tr><td>Gabrieleno</td><td>Modoc</td><td>Shasta</td><td>Other</td></tr></table>	Assiniboine	Hoopa	Mono	Sioux	Apache	Juaneno	Navajo	Smith River	Blackfeet	Kumeyaay	Paiute	Tohono O'Odham	Cahuilla	Karuk	Pima	Tolowa	Cherokee	Luiseno	Pit River	Wintun	Choctaw	Maidu	Pomo	Yaqui	Chumash	MeWuk	Pueblo	Yokut	Dieguneno	Mission	Serreno	Yurok	Gabrieleno	Modoc	Shasta	Other
Assiniboine	Hoopa	Mono	Sioux																																		
Apache	Juaneno	Navajo	Smith River																																		
Blackfeet	Kumeyaay	Paiute	Tohono O'Odham																																		
Cahuilla	Karuk	Pima	Tolowa																																		
Cherokee	Luiseno	Pit River	Wintun																																		
Choctaw	Maidu	Pomo	Yaqui																																		
Chumash	MeWuk	Pueblo	Yokut																																		
Dieguneno	Mission	Serreno	Yurok																																		
Gabrieleno	Modoc	Shasta	Other																																		
05	Chinese																																				
06	Japanese																																				
07	Filipino																																				
09	Other Non-White (e.g. Arabs, Iraqi, Turks)																																				
10	Korean																																				
11	Indochinese																																				
12	Amerasian																																				
13	Cambodian																																				
14	Samoan																																				
15	Asian Indian																																				
16	Hawaiian Native																																				
17	Guamanian																																				
18	Laotian																																				
19	Vietnamese																																				
20	Other Black																																				
21	Other White																																				
26	Other																																				
27	Hmong																																				
28	Mien																																				
29	Other Asian																																				
30	Other Pacific Islander																																				
99	Unknown/Not Reported																																				

FINANCIAL SCREENING

Financially Screening Your HWLA Clients from DMH

*A Brief Overview of the
UMDAP Process*

Overview of Presentation

- What is financial screening and UMDAP?
- Why do we have to do it?
- Ok, now that we know why we have to do it, how do we financially screen a client about to receive DMH services?
 - ✓ *Introduction to the PFI form*
- What do we do if a client has an annual liability and loses their HWLA coverage?

Financial Screening & UMDAP

What is Financial Screening?

- Financial screening is the evaluation of
 - ✓ *Who* can pay for the services rendered
 - ↳ Client or responsible party
 - ↳ Third party payers such as insurance or Medi-Cal
 - ✓ *How much* the client can contribute to paying for services
 - ✓ Whether a client can access or qualifies for benefits

Financial Screening & UMDAP

What is UMDAP?

- The Uniform Method of Determining Ability to Pay (UMDAP) is the process of determining how much a client is responsible to pay for services.
- Based on a sliding fee scale after evaluation of the client's
 - ✓ Income and assets
 - ✓ Allowable expenses

Financial Screening & UMDAP

What is UMDAP? (*continued*)

- With UMDAP, the annual charge period is one year.
- The UMDAP annual liability amount is valid for one year.
 - ✓ Clients cannot be charged until they have become obligated to pay for services they have received.
 - ✓ *Can be adjusted up or down if the client's financial circumstances change.*

The Importance of Financial Screening & UMDAP

Why is financial screening & UMDAP required?

- The UMDAP annual charge period and liability amount apply throughout California.
 - ✓ Ensures that clients are not accidentally charged more than they can afford to pay as determined by the State's sliding fee scale.
- State regulations (Welfare and Institutions Code Section 5872) requires providers to collect from all applicable public and private payers.

This impacts all DMH funding

Overview of the Payer Financial Information Form (PFI)

- The Payer Financial Information (PFI) form has four sections
 - ↳ Client information
 - ↳ Third party payer information (including payer references)
 - ↳ UMDAP Liability Determination
 - ↳ Other (current UMDAP status, treatment information and signatures)

Overview of the Payer Financial Information Form (PFI)

Client Information (lines 1 & 2)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH PAYER FINANCIAL INFORMATION					CONFIDENTIAL CLIENT INFORMATION See W & I Code, Section 5328
CLIENT INFORMATION					
1	CLIENT NAME	SS #			DASH CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	SPOUSE NAME	
THIRD PARTY INFORMATION					

Overview of the Payer Financial Information Form (PFI)

Third Party Payer Information (lines 3-18)

2					<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP			
THIRD PARTY INFORMATION								
3	NO THIRD PARTY PAYER <input type="checkbox"/>							
4	MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL COUNTY CODE / AID CODE/ CIN #		MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE REFERRED		
5	SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO		SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		SSI APPLICATION DATE		
6	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO		GROW <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHY FAMILIES CIN #		
7	MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICARE #	LIFETIME AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO		VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO
8	HMO/PPD <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED	
9	CARRIER ADDRESS						ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	
PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)								
10	NAME OF PAYER			RELATION TO CLIENT		DOB		MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP
11	ADDRESS			CITY		STATE		ZIP CODE
12	SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____							PAYER SS #
13	EMPLOYER				POSITION			IF NOT EMPLOYED, DATE LAST WORKED
14	EMPLOYER'S ADDRESS (Include City, State & Zip Code)							TEL #
15	SPOUSE			ADDRESS (Include City, State & Zip Code)				SPOUSE'S SS #
16	SPOUSE'S EMPLOYER				POSITION			IF NOT EMPLOYED, DATE LAST WORKED
17	SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)							TEL #
18	NEAREST RELATIVE/RELATIONSHIP				ADDRESS (Include City, State & Zip Code)			TEL #
UMDAP LIABILITY DETERMINATION								

Overview of the Payer Financial Information Form (PFI)

UMDAP Liability Determination (lines 19-23)

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings	\$ _____	Court ordered obligations paid monthly	\$ _____	Gross Monthly Family Income	
Checking Accounts	\$ _____	Monthly child care payments (necessary for employment)	\$ _____	Self/Payer	\$ _____
IRA, CD, Market value of stocks, bonds and mutual funds	\$ _____	Monthly dependent support payments	\$ _____	Spouse	\$ _____
TOTAL LIQUID ASSETS	\$ _____	Monthly medical expense payments	\$ _____	Other	\$ _____
Less Asset Allowance	\$ _____	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	\$ _____	TOTAL HOUSEHOLD INCOME	\$ _____
Net Asset Valuation	\$ _____	Total Allowable Expenses	\$ _____	TOTAL FROM BOX 19	\$ _____ +
Monthly Asset Valuation (Divide Net Asset by 12)	\$ _____			SUBTOTAL	\$ _____
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		LESS TOTAL FROM BOX 20	\$ _____ -
Number Dependent on Adjusted Monthly Income (Client Included)				Adjusted Monthly Income	\$ _____
ANNUAL LIABILITY		ANNUAL CHARGE PERIOD		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	
		FROM TO		Payment Plan \$ _____	
				per month for 1 2 3 4 5 6 months.	
23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)					

Overview of the Payer Financial Information Form (PFI)

Other (lines 24-27)

OTHER			
24	PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO
	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED
25	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE	
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		
			DATE

MH 281 Rev. 02/11/2011

Loss of HWLA Coverage

- If your client becomes unenrolled from HWLA or needs annual re-enrollment
 - ✓ Confirm the client's eligibility by verifying
 - ↳ Income at or below 133% of the Federal Poverty Level (FPL)
 - ↳ Continued residency in Los Angeles County.
 - ✓ Refer client to DHS for re-enrollment.

Contacting RMD

RMD Hotline: (213) 480-3444

or e-mail

RevenueManagement@dmh.lacounty.gov

RMD Fax: (213) 252-8880 or (213) 252-8879

**LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYER FINANCIAL INFORMATION**

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1 CLIENT NAME	SS #	DMH CLIENT ID #
2 MAIDEN NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP
SPOUSE NAME		

THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER <input type="checkbox"/>							
4 MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-CAL COUNTY CODE / AID CODE / CIN #		MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR ELIGIBILITY ASSESSMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE REFERRED	
5 SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE		IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON		
6 CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES CIN #		AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 CONSENT FORM SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO	
7 MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY WAY LA <input type="checkbox"/> YES <input type="checkbox"/> NO	HWLA MEMBER #
8 HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CARRIER			GROUP/POLICY/ID #		NAME OF INSURED	
9 CARRIER ADDRESS						ASSIGNMENT / RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10 NAME OF PAYER	RELATION TO CLIENT	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	PAYER CDL/CAL ID
11 ADDRESS	CITY	STATE	ZIP CODE	TEL #
12 SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____				PAYER SS #
13 EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
14 EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
15 SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16 SPOUSE'S EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
17 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
18 NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)		TEL #

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS Savings \$ _____ Checking Accounts \$ _____ IRA, CD, Market value of stocks, bonds and mutual funds \$ _____ TOTAL LIQUID ASSETS \$ _____ Less Asset Allowance \$ _____ Net Asset Valuation \$ _____ Monthly Asset Valuation (Divide Net Asset by 12) \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	20 ALLOWABLE EXPENSES Court ordered obligations paid monthly \$ _____ Monthly child care payments (necessary for employment) \$ _____ Monthly dependent support payments \$ _____ Monthly medical expense payments \$ _____ Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____ Total Allowable Expenses \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	21 ADJUSTED MONTHLY INCOME Gross Monthly Family Income Self/Payer \$ _____ Spouse \$ _____ Other \$ _____ TOTAL HOUSEHOLD INCOME \$ _____ TOTAL FROM BOX 19 \$ _____ + SUBTOTAL \$ _____ LESS TOTAL FROM BOX 20 \$ _____ - Adjusted Monthly Income \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	
22 Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM TO	Payment Plan \$ _____ per month for <u>1 2 3 4 5 6</u> months.
23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24 PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25 ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26 An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
27 I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON			
DATE			

ENROLLMENT PROCESS

Legal Entity Contract Provider

Healthy Way LA Pre-Screening Packet

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**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION**

**Legal Entity Contract Provider
Healthy Way LA (HWLA) New Enrollment Protocol**

OVERVIEW:

- 1) Clinic staff completes a screening with client to review HWLA eligibility criteria.
- 2) If the client meets HWLA eligibility criteria, clinic staff will assist client obtain required original documentation.
 - Proof of Citizenship/Legal Residency
 - Proof of Los Angeles County Residency
 - Proof of income
 - Payor Financial Information (PFI) form
 - HWLA Application
- 3) Clients have 14 days to produce required documentation. However, if they appear to be make a good faith effort to provide the needed documentation, clinic staff will continue to work with the client to obtain the necessary documentation. If the client does not appear to be cooperating, the client will be deemed ineligible for HWLA.
- 4) Clinic staff will mail completed application package to a DHS Enrollment Center with copies of original documentation and an attestation that clinic staff has reviewed the original documentation. Location of DHS Enrollment Centers will be available at a later date.

PROCESS

- 1) The following are the primary eligibility criteria:
 - Age 19-64
 - Income: Federal Poverty Level guideline - 133% or less.
 - Los Angeles County Resident
 - US Citizen/Legal Permanent Resident for 5 years
- 2) Additional DMH-related eligibility requirements are:
 - Within the last 150 days, has the client been seen at a DMH directly operated or contracted clinic for treatment related to a medically necessary mental health condition?
 - OR
 - Within the last 12 months, has the client had two or more visits to a Los Angeles County DMH directly operated or contracted clinic?

3) Clinic staff will verify that the patient meets the eligibility criteria:

- Age: 19-64.
 - Review all documents to ensure that they all indicate the same date of birth, and that the client is age 19-64.
- Income: Federal Poverty Level guideline - 133% or less.
 - Review existing Payer Financial Information (PFI) form in clinic chart.
 - Obtain income documentation (see HWLA Pre-Screening Checklist for list of acceptable documents), and verify that it reflects the information contained in the PFI. If the information does not match, update the PFI. Use the Federal Poverty Level Chart (contained in Pre-Screening Packet) to verify the client is within income guidelines.
- LA County Resident
 - Obtain identity documentation (see HWLA Pre-Screening Checklist for list of acceptable documents). If a client does not have identity documentation, clients must provide citizenship/legal residency documentation in order to obtain a driver's license or ID card. If a client does not have citizenship/legal residency documentation, see the document in the Pre-Screening Packet titled HWLA Guidelines for Obtaining Proof of Citizenship/Permanent Residency and Los Angeles County Residency.
- US Citizen/Legal Permanent Resident for 5 years
 - For clients born in California or another state, clinic staff to assist client in obtaining US Citizenship/Legal Permanent Residency documents. Please refer to 'Legal Entity Contract Provider HWLA Guidelines for Obtaining Proof of Citizenship/Permanent Residency and Los Angeles County Residency.'
 - If unable to obtain a birth certificate, review the list of acceptable citizenship documents to determine what other type of documentation could be obtained.

- 4) When all required documentation has been obtained, clinic staff will review documentation, complete and sign the HWLA Pre-Screening Checklist (contained in Pre-Screening Packet).
- 5) Clinic staff will photocopy all original documents required for enrollment and include the original HWLA application and original attestation in one complete package and mail to the DHS Enrollment Center. Locations of DHS Enrollment Centers will be available at a later date.

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION

LEGAL ENTITY CONTRACT PROVIDER
HWLA PRE-SCREENING CHECKLIST*

**If client is an existing HWLA client, there is no need to complete this form.*

Client Name _____	DMH # _____
Social Security Number _____	Date of Birth _____

Please check the appropriate answer to the following Healthy Way LA (HWLA) pre-screening questions.

If the answer is "No" to any question numbered 1-4, **STOP IMMEDIATELY**. Please inform the client he/she does not qualify for HWLA.

1. Is the client between 19 and 64 years old? ☐ Yes ☐ No

Review the current Payor Financial Information (PFI) form. Confirm that the client's income is as stated on the PFI. If not, update the PFI, then refer to the attached Federal Poverty Level table to determine financial eligibility.

2. Is the client's income at or below 133% of the Federal Poverty Level? ☐ Yes ☐ No

3. Is the client a Los Angeles County resident? ☐ Yes ☐ No

4. Has the client been a U.S. citizen or legal permanent resident the last 5+ years? ☐ Yes ☐ No

IF THE ANSWER IS "YES" TO ALL OF THE ABOVE QUESTIONS, PLEASE CONTINUE.

5. Within the last 150 days, has the client been seen at a DMH directly operated or contracted clinic for treatment related to a medically necessary mental health condition? ☐ Yes ☐ No

6. Within the last 12 months, has the client had two or more visits to a DMH directly operated or contracted clinic? ☐ Yes ☐ No

If the answer to either Question #5 or Question #6 is "Yes," please continue by asking the client to complete a Healthy Way LA application. Next, obtain the documents listed on the reverse side of this form to verify U.S. citizenship or legal permanent residency, Los Angeles County residency, and income.

Complete the reverse side of this form **ONLY** after all documents have been obtained.

HWLA PRE-SCREENING DOCUMENT CHECKLIST

Check one box from each section below indicating which document the client will use to verify U.S. citizenship/legal permanent residency, county residency, and income:

Section A: U.S. Citizenship/Legal Permanent Residency for 5+ years

- ☐ U.S. Passport issued without limitation (expired ones are acceptable)
- ☐ Certificate of Naturalization (N-550 or N-570)
- ☐ Certificate of U.S. Citizenship (N-560 or N-561)
- ☐ U.S. Birth Certificate/Abstract/Application for copy through RMD
- ☐ Permanent Resident Card (Green Card)
- ☐ Verification from the attached list of acceptable documents (please specify):

Section B: Los Angeles County residency

- ☐ California Driver License or Identification Card
- ☐ School Identification Card with a photograph
- ☐ General Relief Identification Card
- ☐ United States Military card (with place of birth listed)
- ☐ Utility bill or phone bill (within last 30 days)

Section C: Income

- ☐ Work paycheck stub (at least 2 recent stubs)
- ☐ Spousal proof of income (acceptable if it is the only source of income)
- ☐ Current business records (for self-employed person)
- ☐ Most recent tax return
- ☐ Award letter/Notice of Action letter (within last 90 days)
- ☐ Signed statement from employer
- ☐ In-kind Verification
- ☐ Affidavit (for self-employed person)

FINAL HWLA PRE-SCREENING QUESTIONS

- | | | |
|---|------------------------------|-----------------------------|
| Are the answers to Questions 1-4 (on previous page) all "Yes?" | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the answer to either Question 5 or 6 (on previous page) "Yes?" | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you obtained or applied for verification documentation for: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| citizenship/legal residency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| county residency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| income? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you placed a copy of the documents obtained in the chart? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did the client sign the Healthy Way LA application? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you completed and signed the Attestation form? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

IF THE ANSWERS TO THE FINAL HWLA PRE-SCREENING QUESTIONS ARE "YES," FORWARD THE ENROLLMENT DOCUMENTS TO THE NEAREST DHS ENROLLMENT CENTER.

HWLA ENROLLMENT ATTESTATION REVIEW OF ORIGINAL CLIENT DOCUMENTATION

Check one box from each section below indicating which document the client has used to verify U.S. citizenship/legal permanent residency, county residency, and income:

Section A: U.S. Citizenship/Legal Permanent Residency for 5+ years

- ☐ U.S. Passport issued without limitation (expired ones are acceptable)
 - ☐ Certificate of Naturalization (N-550 or N-570)
 - ☐ Certificate of U.S. Citizenship (N-560 or N-561)
 - ☐ U.S. Birth Certificate/Abstract
 - ☐ Permanent Resident Card (Green Card)
 - ☐ California Birth Index
 - ☐ Other verification from the attached list of acceptable documents (please specify):
-

Section B: Los Angeles County residency

- ☐ California Driver License or Identification Card
- ☐ School Identification Card with a photograph
- ☐ General Relief Identification Card
- ☐ United States Military card (with place of birth listed)
- ☐ Utility bill, phone bill, or rent receipt (within the last 30 days)

Section C: Income

- ☐ Work paycheck stub (at least 2 recent stubs)
- ☐ Spousal proof of income (acceptable if it is the only source of income)
- ☐ Current business records (for self-employed person)
- ☐ Most recent tax return
- ☐ Award letter/Notice of Action letter (within last 90 days)
- ☐ Signed statement from employer
- ☐ In-kind Verification
- ☐ Affidavit (for self-employed person)

I attest that I have seen the original documents that are indicated above. The documents submitted with this client's Healthy Way LA (HWLA) application are photocopies of the original documentation that is required for HWLA enrollment. I confirm that the client's original documentation has been returned to the client and that the only additional copies are with the client's other financial information as required by the Department of Mental Health.

Provider #

Provider Name

Staff Name (Please print)

E-mail

Phone Number

Signature

Date



Application for Healthy Way LA Matched Program and Verification Checklist

Name: _____ Date: _____
 Patient MRUN: _____ Facility Name: _____
 Preferred Spoken Language: _____ Inpatient Admit Date: _____
 Preferred Written Language: _____ Outpatient Visit Date: _____
 Medical Home/Primary Care Provider: _____

Would you say that in general your health is (circle one): excellent, very good, good, poor, don't know? Pt. refused to answer.

With this document, I apply for Healthy Way LA (HWLA) Matched Program. If I am not eligible for the program, the County will evaluate me for one of the other No-Cost/Low-Cost programs. I understand that this program will help me pay my County medical bills if I meet the eligibility requirements.

I have been informed that the items checked (✓) below are needed to establish my eligibility for the HWLA Matched Program. **This information must be provided no later than** _____.

Failure to provide the requested documents by this due date may result in the denial of the HWLA Matched Program. You must answer our questions and provide the papers we have asked you for, so we can see if you can get help with your medical bills under the HWLA Matched Program. If you do not help us get the papers we requested, you will not be able to get help in paying your County medical bills from any other County program including Ability-To-Pay (ATP) or Outpatient Reduced-Cost Simplified Application (ORSA). This means you will have to pay the full charge for your County medical care.

IF YOU HAVE ANY QUESTIONS OR ARE UNABLE TO GET ANY OF THE PAPERS LISTED BY THE DUE DATE, PLEASE CALL ME RIGHT AWAY TO TALK ABOUT OTHER WAYS TO MEET THESE REQUIREMENTS

Patient/Representative (signature)

Date

Worker's Name (print)

Telephone No.

Social Security Number:

- ☐ Social Security Number
- ☐ Social Security Benefits Award Letter or Check
- ☐ Medicare Card
- ☐ Correspondence from Social Security Administration

Address:

- ☐ Valid California Driver's license
- ☐ Department of Motor Vehicle ID card
- ☐ Rent receipt for month of _____
- ☐ Utility bill for month of _____
- ☐ Letter addressed to you with cancelled U.S. Post Office stamp for month of _____
- ☐ Letter from person providing you with free housing, utilities and/or food

Citizenship/Identity:

- ☐ U.S. Citizenship/National
 - Birth Certificate
 - US Passport
 - Certificate of Naturalization/Citizenship
- ☐ Legal Permanent Resident verification (Green Card)
- ☐ Identification
 - Valid Driver's License (DMV)
 - California DMV identification
 - U.S. Military identification
- ☐ Other (Specify) _____

Income:

- ☐ Copy of most recent paystub (from less than 45 days ago)
- ☐ Statement from employer about your job (how much you are paid, how often and how many hours you work)
- ☐ Last year's Federal Income Tax return (and "Schedule C" if self-employed)
- ☐ Three months of current business records (if income tax return is not available or does not represent current earnings)
- ☐ Property Income (if renting property)

- ☐ Award letter or check/copy of check from any of the following Income sources: (Circle type)

• Unemployment	• Railroad pension
• Insurance Benefits (UIB)	• Retirement Benefits
• Disability Insurance Benefits (DIB)	• Interest income
• Veterans Benefits	• Educational grants
• Social Security Benefits	• Cash contributions from relatives/friends
• Other Unearned Income (Specify) _____	

- ☐ Direct Deposit Statement for Unearned Income
- ☐ Signed statement from person or organization providing cash contribution
- ☐ Letter from person providing you with free housing, utilities and/or food

Income Deductions:

- ☐ Child care receipts, cancelled checks, or statement from babysitter
- ☐ Property expenses (if renting property):
 - Payment records or statement from mortgage company verifying amount owed on other real property
 - Property taxes – Current tax statement
 - Insurance payments – Premium notices or statement from insurance company
 - Utilities paid for rental property – Bills for last three months
 - Upkeep and Repairs – Bills, receipts, records for last three months
- ☐ Child Support/ Spousal Support
 - Court order indicating amount of payment and
 - Cancelled check or money order receipt verifying amount paid
- ☐ Medical insurance premium expenses – Paycheck stub, employer's statement, cancelled check, or receipt

Other:

DRAFT

After we review the documents you provide, you will be notified whether your HWLA Matched Program application is approved or denied. If it is denied, you have the right to appeal.

As an applicant to HWLA, you have the following internal grievance and appeal rights:

1. You have the right to appeal a decision that you do not qualify for HWLA Matched Program. That means that if you disagree, you can have us review the decision to see if it is correct. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of the Notice of Action which tells you about the denial. It can take up to 45 days for Healthy Way LA (HWLA) to decide your appeal.
2. You also have the right to file a grievance. A grievance is a formal statement of dissatisfaction or complaint about something that HWLA or its staff did that is given to HWLA to be investigated and resolved. If you have a grievance, you must let us know within **60 days** of the date of the event that made you unhappy. It can take HWLA up to 60 days to resolve your grievance.

To ask for an appeal or file a grievance, call HWLA Member Services at 1(877) 333-4952. If you have problems hearing or speaking, call TTY/TDD at 1(866) 923-4952. We will help you. You can also ask for your appeal or file your grievance by writing or sending a fax to: **Healthy Way LA Member Services, 1100 Corporate Center Drive, Suite 100, Monterey Park, CA 91754, Fax 1(626) 308-1582.** We have forms you can use, but you do not have to use them. Grievances and appeals not related to eligibility can also be filed at the medical home to which you will be assigned.

3. You have the right to speak for yourself during the grievance or appeal process or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.
4. You may send written comments, documents, records and other information about your grievance or appeal. For appeals, you may also ask for a hearing in person or by telephone where you can give the reasons why you do not agree and examine and cross examine witnesses.
5. Before and during the appeal process, you will be able to look at your case file. The case file includes our notes on your application, supporting papers or other information related to your appeal.
6. If, after we make our decision on your appeal you are still unhappy, you can ask for a State Fair Hearing. You may ask for a State Fair Hearing **after** you have finished the HWLA appeal process and have a letter with our decision. There is no State Fair Hearing after a grievance is resolved.

**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION**

FEDERAL POVERTY LEVEL CHART PER MONTH BY FAMILY SIZE

Use the client's current Payor Financial Information (PFI) form and the chart below to determine if the client meets the financial criteria for Healthy Way LA. Based on family size, a client's monthly income as documented in the PFI must be equal to or less than the figures below.

Family Size	133% Federal Poverty Level
1	\$1207
2	\$1631
3	\$2054
4	\$2478
5	\$2901
6	\$3324
7	\$3748
8	\$4171
9	\$4594
10	\$5019
Each additional person	Add \$424 per person

**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION**

Legal Entity Contract Provider

**Acceptable U.S. Citizenship/Legal Permanent Residency and Los Angeles
County Residency Documents**

U.S. Citizenship and Legal Permanent Residency

U.S. Passport issued without limitation (expired acceptable)
Certificate of Naturalization (N-550 or N-570)
Certificate of U.S. Citizenship (N-560 or N-561)
U.S. Birth Certificate or Abstract (certified only, not informational)
Certification of Report of Birth (DS-1350)
Report of Birth Abroad of a U.S. Citizen (FS-240)
State Department of Certification of Birth (FS-545 or DS1350)
U.S. Citizen Identification Card (I-197 or I-175)
American Indian Card
Northern Marianas Card (I-183)
Final adoption decree showing a U.S. place of birth
Proof of adoption of a child born outside U.S. and in the legal/physical custody
of the U.S. citizen parent (IR-3 or IR-4)
Proof of U.S. civil service employment before June 1, 1976
U.S. Military service record showing a U.S. place of birth
U.S. hospital record made at the time of birth
Life , Health, or other insurance record
Religious record recorded in the U.S. within 3 months of birth showing U.S.
place of birth and birth date and age
Early school record showing a U.S. place of birth, date of admission, birth date,
names and places of birth of parents
Federal or State census record that shows the applicant's age and U.S.
citizenship or place of birth
Seneca Indian tribal census record
Bureau of Indian Affairs Navajo Indians tribal census record
U.S. State Vital Statistics birth registration notification
A delayed U.S. public birth record that was recorded more than 5 years after
the person's birth
Statement signed by doctor or midwife present at birth
Roll of Alaska Native from the Bureau of Indian Affairs
Admission papers from a nursing or skilled care facility, or other institution
that show a U.S. place of birth
Medical record (NOT an immunization record)

Los Angeles County Residency

California Driver License or Identification Card
School Identification Card with a photograph
General Relief Identification Card
United States Military card (with place of birth listed)
Utility bill or phone bill (within last 30 days)

**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION**

**Legal Entity Contract Provider
HwLA Guidelines for Obtaining Proof of Citizenship/Permanent Residency and Los Angeles County Residency**

Birth Certificate

- If the client was born in Los Angeles County and has valid California photo identification, the client may go to one of the following Los Angeles County Registrar-Recorder/County Clerk offices to request a birth certificate. The client will be asked to present the identification when making the request. The cost is \$19.

1028 W. Avenue J2	Lancaster	(661) 945-6446	Hrs: 8:30 a.m. - 4:30 p.m., M-F
11701 S. La Cienega Blvd, 6th Floor	LAX Courthouse	(310) 727-6142	Hrs: 8:30 a.m. - 4:30 p.m., M-F
4716 East Cesar Chavez Avenue	Los Angeles	(323) 260-2991	Hrs: 8:30 a.m. - 4:30 p.m., M-F
7807 S. Compton Avenue	Los Angeles	(323) 586-6192	Hrs: 8:30 a.m. - 4:30 p.m., M-F
12400 Imperial Highway	Norwalk	(562) 462-2137	Hrs: 8:00 a.m. - 5:00 p.m., M-F
14340 West Sylvan Street	Van Nuys	(818) 376-3700	Hrs: 8:30 a.m. - 4:30 p.m., M-F

The Norwalk facility is open 8 a.m. - 7 p.m. on the third Thursday of every month.

Same day service is available for births 1964 to present. Births prior to 1964 will be mailed within approximately 20 business days.

- If the client was born in Los Angeles County but does not have valid California photo identification, the client must complete 2 forms: 1) the Application For Birth Record and 2) the Certificate of Identity/Sworn Statement - Birth, Death & Public Marriage form. The Certificate of Identity **MUST** be notarized. The client must provide two witnesses who possess valid identification to present to the notary. The notary will keep a record of these two witnesses. Contract provider staff may not be one of the witnesses.

Information to be included on the application includes the following:

- Name given at birth
 - City of birth
 - Father's name
 - Mother's maiden name
 - If the client has been adopted or had a legal name change, a written request must be submitted to State Department of Health Services, Office of Vital Records - M.S. 1503, PO Box 997410, Sacramento, CA 95899-7410. See the next section for submitting a request to the state.
- For a client born outside of Los Angeles County but in California, an Application for State of California Certified Copy of Birth Record and Sworn Statement must be completed. The Sworn Statement must be notarized. Notary procedures/rules as described above apply. The cost is \$16.
- For out of state birth certificates, documentation requirements vary from state to state, and can vary within states from county to county. In general, gather the following information from the client:
- Name as it appears on birth certificate (if adopted, use adoptive name):
 - Date of birth (MM/DD/YYYY)
 - City of birth
 - County of birth
 - State of birth
 - Name of hospital
 - Father's name as is appears on birth certificate
 - Mother's name as it appears on birth certificate, including maiden name
 - To request information regarding required documentation for a specific state, contact Revenue Management at the RMD Hotline, 213-480-3444, or via e-mail at revenuemanagement@dmh.lacounty.gov

Identification Card

The current cost for a California Identification Card is \$27. An appointment with the DMV may be scheduled on-line at <http://www.dmv.ca.gov/> or by calling 1-800-777-0133. The client may also go to the DMV unscheduled. The client will also be required to complete an identification card application (DL44), which may only be obtained at a DMV office.



COUNTY OF LOS ANGELES
REGISTRAR-RECORDER/COUNTY CLERK
P.O. BOX 489, NORWALK, CALIFORNIA 90651-0489 - www.lavote.net

"Enriching Lives"

DEAN C. LOGAN

Registrar-Recorder/County Clerk

CERTIFICATE OF IDENTITY/SWORN STATEMENT - BIRTH, DEATH & PUBLIC MARRIAGE

In accordance with California State Law, the following identifying information is required to obtain a certified copy of Birth, Death or Public Marriage Certificate. You must be one of the following to receive an authorized copy of a birth, death or public marriage record, individual named on certificate, parent, child, legal guardian/custodian, grandparents, grandchild, sibling, spouse/domestic partner, attorney for individual/estate of individual or representative of an adoption agency (birth only), funeral director or agent/employee (death only).

This certificate must be signed in the presence of a Notary.

Name(s) on Certificate	Relationship

I, _____, declare under penalty of perjury under the laws of the State of
(Print Name)

California, that I am an authorized person, as defined in California Health and Safety Code Section 103526(c), and am eligible to receive a certified copy of the birth or death record for the individual(s) listed above.

Subscribed to the _____ day of _____ 20____, at _____, _____.
(Day) (Month) (City) (State)

(Signature)

CERTIFICATE OF ACKNOWLEDGEMENT

STATE OF CALIFORNIA)
) ss
County of)

On _____, before me _____ personally appeared
(Insert name and title of officer here)

_____, who proved to me on the basis of satisfactory evidence, to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

(NOTARY SEAL)

NOTARY SIGNATURE

APPLICATION FOR BIRTH RECORD

Pursuant to Health and Safety Code 103526, the following individuals are entitled to an AUTHORIZED Certified Copy of a birth record.

- ◆ The registrant or a parent or legal guardian of the registrant
- ◆ A party entitled to receive the record as a result of a court order, or an attorney or a licensed adoption agency seeking the birth record in order to comply with the requirements of Section 3140 or 7603 of the Family Code.
- ◆ A member of a law enforcement agency or a representative of another governmental agency, as provided by law, who is conducting official business.
- ◆ A child, grandparent, grandchild, sibling, spouse or domestic partner of the registrant
- ◆ An attorney representing the registrant or the registrant's estate, or any person or agency empowered by statute or appointed by a court to act on behalf of the registrant or the registrant's estate.

If applying in person the application must be signed in the presence of the cashier.

Those who are not authorized may receive an INFORMATIONAL Certified Copy with the words "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY" imprinted across the face of the copy.

MAIL REQUESTS MUST BE ACCOMPANIED BY A NOTARIZED CERTIFICATE OF IDENTITY

☐ I am requesting an **AUTHORIZED** copy

☐ I am requesting an **INFORMATIONAL** copy

AGE LAST BIRTHDAY – EDAD CUMPLIDA	NUMBER OF COPIES NUMERO DE COPIAS			FOR RECORDER USE ONLY
Month/Mes Day/Día Year/Año				
Date of Birth – Fecha De Nacimiento				
NAME GIVEN AT BIRTH (first, middle, last) – NOMBRE DE NACIMIENTO (primero, segundo, apellido)				File Number
CITY OF BIRTH – CIUDAD DE NACIMIENTO				Searched _____
NAME OF FATHER – NOMBRE DEL PADRE				Doubled _____
MAIDEN NAME OF MOTHER – NOMBRE DE SOLTERA DE LA MADRE				
RELATIONSHIP TO REGISTRANT (SEE ABOVE) – PARENTESCO CON LAS PERSONA REGISTRADA (VEÁSE ARRIBA)				
I _____ certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date _____ Signature _____				Veterans-See reverse side of first copy Veteranos-Vean el dorso de la segunda copia

DL/ID _____

NAME/NOMBRE		
STREET ADDRESS/NUMERO Y CALLE		
CITY /CIUDAD	STATE/ESTADO	ZIP/ZONA POSTAL

SPECIAL NOTICE TO VETERANS

You may be eligible for a free certified copy if you are applying for a veteran's pension or certain other Veteran's Administration benefits. (Section 6107, Government Code State of California)

THIS DOES NOT APPLY TO SOCIAL SECURITY AND OTHER CIVILIAN BENEFITS, EVEN IF YOU ARE A VETERAN.

If you believe you qualify for a free certified copy under these provisions, complete the following affidavit.

I hereby apply for a free certified copy of the record as shown on the reverse side and declare under penalty of perjury that the free copy is to be furnished to

_____ in a claim for _____
FEDERAL OR STATE AGENCY TYPE OF BENEFIT

DATE SIGNATURE OF VETERAN OR AUTHORIZED AGENT RELATIONSHIP OF AGENT

NUMBER-STREET

CITY STATE ZIP

Note: The free copy issued on this affidavit will bear the following wording:

This certified copy has been issued free of charge on the declaration under penalty of perjury that it is to be used in a claim to the Federal Government or the State of California for veteran's benefits.

Los Angeles County - Department of Mental Health

Revenue Management Division



ENROLLMENT PROCESS

DIRECTLY OPERATED PROGRAMS

The contents for the Healthy Way LA Tool Kit will be made available via an RMD Bulletin and on the Revenue Management Division (RMD) intranet website at: <http://dmhhqportal1/sites/RMD/default.aspx>.

Should you have any questions please contact RMD at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.

Healthy Way LA Eligibility Check Request

Date of Request: _____

Contact Information

Provider no. & name: _____

Phone no.: _____ Fax: _____

Requested by: _____

e-mail address: _____

Requested Information

Please identify name of client(s) whom you would like RMD to verify enrollment in Healthy Way LA. Provide as much information as possible.

a. Full Name	_____
b. Date of Birth	_____
c. Sex	_____
d. Address	_____ _____

e. Full Name	_____
f. Date of Birth	_____
g. Sex	_____
h. Address	_____ _____

RMD Tracking Information (RMD Use Only)

Request no.: _____

Opened by: _____

Request assigned to: _____

Closed by: _____

Date opened: _____

Date assigned: _____

Date closed: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Fax your request to Revenue Management Division at (213) 252-8889

MEDICAL RECORD REQUIREMENTS

HWLA Documentation Requirements-Community Partners

Version 2: 6/29/2011

Clinical Records

Community Partners providing mental health services must ensure that there is a mental health clinical record for all clients receiving services under Healthy Way Los Angeles (HWLA) to document the services the client received. The clinical record shall be maintained by the Community Partner and it is up to the Community Partner to ensure that all federal, state and local laws and regulations regarding the mental health clinical record are adhered to. Community Partners may have either a paper clinical record or an electronic medical record (EMR) which shall include complete, accurate and current documentation of any and all information related to the client's mental illness. Clinical records are considered legal documents.

Some of the purposes of a clinical record are as follows:

- To evaluate and plan the client's individual treatment and care
- To analyze, study and evaluate the quality of care rendered to clients
- To serve as a means of communication for continuity of care and to link past and current services
- To protect the legal interest of the client, facility/program and/or the therapist

All information contained in the clinical record is considered confidential information and is protected under Welfare & Institutions Code 5328. Professionals may share Protected Health Information (PHI) with other professionals providing care to a person without client authorization. Information in the clinical record must adhere to all HIPAA Privacy and Security regulations. The Los Angeles County Department of Mental Health (DMH) does not provide legal advice to its contractors; Community Partners must seek legal advice from their own legal counsel in order to interpret laws or regulatory codes and to answer any questions regarding release of information.

The clinical record shall include complete, accurate and current documentation of any and all information related to a client. It must contain demographics, history, support for the diagnosis and/or condition of the client, treatment provided and the current status/condition of the client.

Community Partners are responsible for creating their own chart structure for the HWLA program.

Clinical Forms

DMH provides official clinical forms for use within a paper clinical record. Official clinical forms have been designed in order to meet required elements based on:

- Clinical Record Guidelines
- Clinical need
- Funding source reimbursement rules
- HIPAA Procedure Code definitions
- Integrated System (IS) fields

- State Contract requirements
- LACDMH Policy and Procedures

Approved forms are categorized into four different categories noted below. Please note that these are described in terms of having a paper clinical record. For Community Partners with an EMR, please refer to Clinical Records Bulletin Edition 2011-03 located at http://dmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/clinical_records_bulletins.html for information regarding how to incorporate the below category of forms into an EMR.

1. **Required (R):** Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.
2. **Required Data Elements (RDE):** Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy; however, the layout and presentation of the form is up to Contractors.
3. **Optional (OP):** Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form.
4. **Ownership (OW):** Forms which are required by state or federal law/code or County/Department policy/procedure but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and to design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code.

Many approved Clinical Forms can be found on the DMH internet at www.dmh.lacounty.gov under Clinical Tools. Below is a sample listing of clinical forms that may be found in the Community Partner Mental Health Clinical Record and the associated category of form.

Sample Forms

Client Face Sheet MHMIS or IS – MH 224A - (RDE)
 Contact Information - MH 525 - (OP)
 Close Outpatient Episode – MH 224B - (RDE)
 Open Outpatient Episode – MH 224B - (RDE)
 Payor Financial Information (PFI) – MH 281 - (R)
 Consent for Services – MH 500 - (OW)
 Consent to Photograph/Audio Record – MH 528 - (OW)
 Consent for Telemental Health Services – MH 652 - (OW)
 Advance Health Care Directive – MH 635 - (OW)
 Acknowledge of Receipt (Privacy Notice) – MH 601 - (OW)
 Client's Request for Restriction of Use & Disclosure of Health Information – MH 614 - (OW)
 Letter of Denial Regarding Client's Request for Confidential Communications – MH 616 - (OW)
 Client's Request for Confidential Communications – MH 615 – (OW)
 Accounting Tracking Sheet – MH 612 (OW)

DMH Response to Primary Care Provider – MH 649B - (OP)
Primary Care Provider Referral to DMH – MH 649A - (OP)
Auth for Request or Use/Disclosure of PHI - MH 602 - (OW)
Final Letter to Client for Review of Denial - MH606 - (OW)
Client Request for Review of Denial to PHI - MH 605 – (OW)
Letter Response to Client Request for PHI - MH 604 – (OW)
Client Request for Access to PHI - MH 603 – (OW)
Letter Responding to Request to Amend/Correct Health Information – MH 608 - (OW)
Request to Amend/Correct PHI – MH 607 - (OW)
Letter Responding to Client's Request for Accounting of Disclosures – MH 613 - (OW)
Request for Accounting of Disclosures – MH 611 - (OW)
DMH FAX Cover for Transmitting PHI – MH 617 - (OW)
Representation of Researcher to Review PHI Held by LAC DMH to Prepare for Research – MH 619 - (OW)
Representation of Researcher to Review PHI of Decedents Held by LAC DMH to Prepare for Research – MH 620 - (OW)
Diagnosis Information – MH 501 - (RDE)
Special Program Client Care Coordination Plan (CCCCP) – MH 651 - (R)
Co-Occurring Joint Action Council (COJAC) Screening Instrument – MH 659 - (R)
Adult Short Assessment – MH 678 - (R)
Adult Assessment Addendum – MH 532A - (OP)
Discharge Summary - MH 517 - (OP)
Progress Notes - MH 515 (the audit trail for all services) - (OP)
Case Presentation - MH 514 - (OP)

General Documentation Guidelines

The clinical record must clearly identify that the client meets Medical Necessity in order for mental health services to be reimbursed. Medical Necessity is comprised of three criteria:

1. An included diagnosis from DSM
2. Impairments that result from the included mental health diagnosis
3. Interventions that are directed towards improving the client impairments, symptoms or behaviors.

These three criteria of Medical Necessity are supported throughout the “clinical loop” which is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are claimable for reimbursement. The sequence of documentation on which Medical Necessity requirements converge is:

1. The Assessment
2. The Client Care Plan
3. The Progress Note

Assessment Guidelines:

An assessment must be present in the Clinical Record of each client receiving mental health services. The Assessment must document the symptoms, behaviors and impairments in life functioning for the client and a 5 Axis DSM diagnosis.

The DMH approved Required Assessment form (MH 678) must be used for the Assessment and must be completed by the end of the 2nd claimed session for the client.

Client Care Plans:

A client care plan must be present in the Clinical Record of each client receiving mental health services. The Client Care Plan must document the short-term goals (objectives) of mental health treatment in specific, measurable, attainable, realistic, and time-bound terms. The Client Care Plan must also document the interventions mental health staff will provide in order to assist the client in achieving the identified objective for the client. The client must participate in the development of their Client Care Plan and must sign the plan that is developed.

The DMH approved Required Special Program CCCP form (MH 651) must be used for the Client Care Plan and must be completed by the end of the 2nd claimed session for the client.

Progress Notes:

A progress note must be present in the Clinical Record for each service provided to the client prior to a claim being submitted. The Progress Note must clearly document:

1. The date of service
2. Procedure Code (if the service is being claimed)
3. Length of service for all participating staff including face to face time and other time
 - a. Face-to-face time is the amount of time where services were directed towards the client
 - b. Other time is the amount of time spent providing a service that was not directed towards the client, travel time, and documentation time
4. Description of the service provided
 - a. The intervention that was attempted or accomplished by each participating staff
5. Any changes in the client's status
6. Signature of the Rendering Provider

Community Partners may use the DMH approved Progress Note (MH 515) or they must create one of their own so long as it captures the above information.

HWLA Documentation Requirements-Directly-Operated Version 6/27/2011

Clinical Records

Directly-Operated programs must adhere to LAC-DMH Policy and Procedures 104.1 and 104.8 regarding the maintenance of Clinical Records and the general documentation guidelines for all HWLA enrollees. In addition, all Directly-Operated programs must adhere to the Clinical Records Guidelines.

HWLA enrollees will utilize the same chart order as all other clients being seen by the Directly-Operated Agency. For the majority of agencies, HWLA enrollees will have an eight part chart order in accord with the official eight part chart order for the Department.

Only DMH approved Clinical Forms can be used by Directly-Operated programs. Many Clinical Forms can be found on the DMH internet at www.dmh.lacounty.gov under Clinical Tools.

Documentation Guidelines

Even though HWLA enrollees are not reimbursed through Medi-Cal, all Directly-Operated Programs must continue to adhere to the Organizational Providers Manual as noted in DMH Policy & Procedure 104.9. In accord with the Organizational Providers Manual, the clinical record must clearly identify that the client meets Medical Necessity in order for mental health services to be reimbursed. Medical Necessity is comprised of three criteria:

1. An included diagnosis from DSM
2. Impairments that result from the included mental health diagnosis
3. Interventions that are directed towards improving the client impairments, symptoms or behaviors.

These three criteria of Medical Necessity are supported throughout the “clinical loop” which is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are claimable for reimbursement. The sequence of documentation on which Medical Necessity requirements converge is:

1. The Assessment
2. The Client Care Plan
3. the Progress Note

Assessment Guidelines:

In accord with the Organizational Providers Manual, an assessment must be present in the Clinical Record of each client receiving mental health services.

Directly-Operated programs must use a DMH Approved Assessment form. The DMH approved Adult Short Assessment form (MH 678) may be used for Tier 1 and Tier 2 HWLA enrollees for the Assessment instead of the full Adult Initial Assessment (MH 532). Directly-Operated programs may choose to use the Adult Initial Assessment if they feel a longer assessment is needed. Even though DMH allows up to two months

for the completion of the assessment (per the Organizational Providers Manual), best practice suggests that an assessment be claimed prior to treatment services being provided. For HWLA enrollees under the Tier 1 and Tier 2 programs, it is recommended that the assessment be completed by the end of the 2nd visit with the client.

Client Care Plans:

A client care plan must be present in the Clinical Record of each client receiving on-going specialty mental health services per the Organizational Providers Manual.

Directly-Operated programs must use a DMH Approved Client Care Plan form. The DMH approved Special Program CCCP form (MH 651) may be used for HWLA enrollees in Tier 1 or Tier 2 instead of the full CCCP (MH 636). Directly-Operated Programs may choose to use the standard CCCP. Similar to the Assessment, best practice suggests that a client care plan be developed prior to providing treatment services. It is recommended that the Client Care Plan be completed by the end of the 2nd visit with the client.

Progress Notes:

A progress note must be present in the Clinical Record for each service provided to the client prior to a claim being submitted in accord with the Organizational Providers Manual. The Progress Note must clearly document:

1. The date of service
2. Procedure Code (if the service is entered in the IS)
3. Length of service for all participating staff including face to face time and other time
 - a. Face-to-face time is the amount of time where services were directed towards the client
 - b. Other time is the amount of time spent providing a service that was not directed towards the client, travel time, and documentation time
4. Description of the service provided
 - a. The intervention that was attempted or accomplished by each participating staff
5. Any changes in the client's status
6. Signature of the Rendering Provider

Directly-Operated programs must use the DMH approved Progress Note (MH 515) or NCR Progress Note (MH 515NCR).

Please refer to the Organizational Providers Manual and the Procedure Codes Guide for additional information regarding documentation and procedure codes.

HWLA Documentation Requirements-Legal Entities

Version 1: 6/27/2011

Clinical Records

Legal Entities providing mental health services must ensure there is a mental health clinical record for all clients receiving services as a Healthy Way Los Angeles (HWLA) enrollee to document the services the client received. The clinical record shall be maintained by the Legal Entity and it is up to the Legal Entity to ensure that all federal, state and local laws and regulations regarding the mental health clinical record are adhered to in accord with DMH Policy & Procedure 104.1. Legal Entities may have either a paper clinical record or an electronic medical record (EMR) which shall include complete, accurate and current documentation of any and all information related to the client's mental illness. Clinical records are considered legal documents.

Some of the purposes of a clinical record are as follows:

- To evaluate and plan the client's individual treatment and care
- To analyze, study and evaluate the quality of care rendered to clients
- To serve as a means of communication for continuity of care and to link past and current services
- To protect the legal interest of the client, facility/program and/or the therapist

All information contained in the clinical record is considered confidential information and is protected under Welfare & Institutions Code 5328. Professionals may share Protected Health Information (PHI) with other professionals providing care to a person without client authorization. Information in the clinical record must adhere to all HIPAA Privacy and Security regulations. The Los Angeles County Department of Mental Health (DMH) does not provide legal advice to its contractors; Legal Entities must seek legal advice from their own legal counsel in order to interpret laws or regulatory codes and to answer any questions regarding release of information.

The clinical record shall include complete, accurate and current documentation of any and all information related to a client. It must contain demographics, history, support for the diagnosis and/or condition of the client, treatment provided and the current status/condition of the client.

Legal Entities are responsible for creating their own chart structure for HWLA enrollees.

Clinical Forms

DMH provides official clinical forms for use within a paper clinical record. Official clinical forms have been designed in order to meet required elements based on:

- Clinical Record Guidelines
- Clinical need
- Funding source reimbursement rules
- HIPAA Procedure Code definitions
- Integrated System (IS) fields
- State Contract requirements

- **LACDMH Policy and Procedures**

Approved forms are categorized into four different categories noted below. Please note that these are described in terms of having a paper clinical record. For Legal Entities with an EMR, please refer to Clinical Records Bulletin Edition 2011-03 located at http://dmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/clinical_records_bulletins.html for information regarding how to incorporate the below category of forms into an EMR.

1. **Required (R):** Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.
2. **Required Data Elements (RDE):** Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy; however, the layout and presentation of the form is up to Contractors.
3. **Optional (OP):** Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form.
4. **Ownership (OW):** Forms which are required by state or federal law/code or County/Department policy/procedure but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and to design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code.

Many approved Clinical Forms can be found on the DMH internet at www.dmh.lacounty.gov under Clinical Tools. Below is a sample listing of clinical forms that may be found in the Community Partner Mental Health Clinical Record and the associated category of form.

Sample Forms for use with HWLA enrollees

Client Face Sheet MHMIS or IS – MH 224A - (RDE)
Contact Information - MH 525 - (OP)
Close Outpatient Episode – MH 224B - (RDE)
Open Outpatient Episode – MH 224B - (RDE)
Payor Financial Information (PFI) – MH 281 - (R)
Consent for Services – MH 500 - (OW)
Consent to Photograph/Audio Record – MH 528 - (OW)
Consent for Telemental Health Services – MH 652 - (OW)
Advance Health Care Directive – MH 635 - (OW)
Acknowledge of Receipt (Privacy Notice) – MH 601 - (OW)
Client's Request for Restriction of Use & Disclosure of Health Information – MH 614 - (OW)
Letter of Denial Regarding Client's Request for Confidential Communications – MH 616 - (OW)
Client's Request for Confidential Communications – MH 615 – (OW)
Accounting Tracking Sheet – MH 612 (OW)
DMH Response to Primary Care Provider – MH 649B - (OP)

Primary Care Provider Referral to DMH – MH 649A - (OP)
Auth for Request or Use/Disclosure of PHI - MH 602 - (OW)
Final Letter to Client for Review of Denial - MH606 - (OW)
Client Request for Review of Denial to PHI - MH 605 – (OW)
Letter Response to Client Request for PHI - MH 604 – (OW)
Client Request for Access to PHI - MH 603 – (OW)
Letter Responding to Request to Amend/Correct Health Information – MH 608 - (OW)
Request to Amend/Correct PHI – MH 607 - (OW)
Letter Responding to Client's Request for Accounting of Disclosures – MH 613 - (OW)
Request for Accounting of Disclosures – MH 611 - (OW)
DMH FAX Cover for Transmitting PHI – MH 617 - (OW)
Representation of Researcher to Review PHI Held by LAC DMH to Prepare for Research – MH 619 - (OW)
Representation of Researcher to Review PHI of Decedents Held by LAC DMH to Prepare for Research – MH 620 - (OW)
Diagnosis Information – MH 501 - (RDE)
Special Program Client Care Coordination Plan (CCCP) – MH 651 - (R)
Co-Occurring Joint Action Council (COJAC) Screening Instrument – MH 659 - (R)
Adult Short Assessment – MH 678 - (R)
Adult Assessment Addendum – MH 532A - (OP)
Discharge Summary - MH 517 - (OP)
Progress Notes - MH 515 (the audit trail for all services) - (OP)
Case Presentation - MH 514 - (OP)

General Documentation Guidelines

Even though HWLA enrollees are not reimbursed through Medi-Cal, all Legal Entities must continue to adhere to the Organizational Providers Manual as noted in DMH Policy & Procedure 104.9. In accord with the Organizational Providers Manual, the clinical record must clearly identify that the client meets Medical Necessity in order for mental health services to be reimbursed. Medical Necessity is comprised of three criteria:

1. An included diagnosis from DSM
2. Impairments that result from the included mental health diagnosis
3. Interventions that are directed towards improving the client impairments, symptoms or behaviors.

These three criteria of Medical Necessity are supported throughout the “clinical loop” which is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are claimable for reimbursement. The sequence of documentation on which Medical Necessity requirements converge is:

1. The Assessment
2. The Client Care Plan
3. The Progress Note

Assessment Guidelines:

In accord with the Organizational Providers Manual, an assessment must be present in the Clinical Record of each client receiving mental health services.

The Assessment is a Required form for Legal Entities. The DMH approved Adult Short Assessment form (MH 678) may be used for Tier 1 and Tier 2 HWLA enrollees for the

Assessment instead of the full Adult Initial Assessment (MH 532). Legal Entities may choose to use the Adult Initial Assessment if they feel a longer assessment is needed. Even though DMH allows up to two months for the completion of the assessment (per the Organizational Providers Manual), best practice suggests that an assessment be claimed prior to treatment services being provided. For HWLA enrollees under the Tier 1 and Tier 2 programs, it is recommended that the assessment be completed by the end of the 2nd visit with the client.

Client Care Plans:

A client care plan must be present in the Clinical Record of each client receiving ongoing specialty mental health services per the Organizational Providers Manual.

The Client Care Plan is a Required form for Legal Entities. The DMH approved Special Program CCCP form (MH 651) may be used for HWLA enrollees in Tier 1 or Tier 2 instead of the full CCCP (MH 636). Legal Entities may choose to use the standard CCCP. Similar to the Assessment, best practice suggests that a client care plan be developed prior to providing treatment services. It is recommended that the Client Care Plan be completed by the end of the 2nd visit with the client.

Progress Notes:

A progress note must be present in the Clinical Record for each service provided to the client prior to a claim being submitted in accord with the Organizational Providers Manual. The Progress Note must clearly document:

1. The date of service
2. Procedure Code (if the service is entered in the IS)
3. Length of service for all participating staff including face to face time and other time
 - a. Face-to-face time is the amount of time where services were directed towards the client
 - b. Other time is the amount of time spent providing a service that was not directed towards the client, travel time, and documentation time
4. Description of the service provided
 - a. The intervention that was attempted or accomplished by each participating staff
5. Any changes in the client's status
6. Signature of the Rendering Provider

Legal Entities may use the DMH approved Progress Note (MH 515) or they may create one of their own so long as it captures the above information.

Please refer to the Organizational Providers Manual and the Procedure Codes Guide for additional information regarding documentation and procedure codes.

CHART ORDER – FOUR-PART COMMUNITY PARTNERS

<p style="text-align: center;"><u>Section 1 – Administration, Consents & Notices</u></p> <p>Client Face Sheet MHMIS or IS – MH 224A - (RDE) Contact Information - MH 525 - (OP) Transfer of Single Fixed Point of Responsibility – MH 530 - (RDE) Close Outpatient Episode – MH 224B - (RDE) Open Outpatient Episode – MH 224B - (RDE) Payor Financial Information (PFI) – MH 281 - (R) Consent for Services – MH 500 - (OW) Consent to Photograph/Audio Record – MH 528 - (OW) Consent for Telemental Health Services – MH 652 - (OW) Advance Health Care Directive – MH 635 - (OW) Acknowledge of Receipt (Privacy Notice) – MH 601 - (OW) Client's Request for Restriction of Use & Disclosure of Health Information – MH 614 - (OW) Letter of Denial Regarding Client's Request for Confidential Communications – MH 616 - (OW) Client's Request for Confidential Communications – MH 615 - (OW) CHART ORDER</p>	<p style="text-align: center;"><u>Section 2 – Correspondence</u></p> <p>Accounting Tracking Sheet – MH 612 (always top document)(OW) DMH Response to Primary Care Provider – MH 649B - (OP) Primary Care Provider Referral to DMH – MH 649A - (OP) Subpoenas/Court Orders Auth for Request or Use/Disclosure of PHI - MH 602 - (OW) Final Letter to Client for Review of Denial - MH606 - (OW) Client Request for Review of Denial to PHI - MH 605 - (OW) Letter Response to Client Request for PHI - MH 604 - (OW) Client Request for Access to PHI - MH 603 - (OW) Letter Responding to Request to Amend/Correct Health Information – MH 608 - (OW) Request to Amend/Correct PHI – MH 607 - (OW) Letter Responding to Client's Request for Accounting of Disclosures – MH 613 - (OW) Request for Accounting of Disclosures – MH 611 - (OW) DMH FAX Cover for Transmitting PHI – MH 617 - (OW) Representation of Researcher to Review PHI Held by LAC DMH to Prepare for Research – MH 619 - (OW) Representation of Researcher to Review PHI of Decedents Held by LAC DMH to Prepare for Research – MH 620 - (OW)</p>
<p style="text-align: center;"><u>Section 3 – Assessments, COD, & Plans</u></p> <p>Diagnosis Information – MH 501 - (RDE) Special Program Client Care Coordination Plan (CCCP) – MH 651 - (R) Adult Short Assessment – MH 678 - (R) Adult Assessment Addendum – MH 532A - (OP) 5150 & related documentation (Application for 72-hour Detention For Evaluation/Treatment) – MH 302 - (R)</p>	<p style="text-align: center;"><u>Section 4 – Progress Notes</u></p> <p>For all services except Med Support (contents sequential, most recent on top) Discharge Summary - MH 517 - (OP) Progress Notes - MH 515 (the audit trail for all services) - (OP) Case Presentation - MH 514 - (OP)</p>

- R** - Required Form = Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.
- RDE** - Required Data Elements = Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy, however, the layout and presentation of the form is up to Contractors.
- OP** - Optional Form = Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form.
- OW** - Ownership Form = Forms which are required by state or federal law/code or County/Department policy/procedures but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and to design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code.

SECTION 1

CLIENT FACE SHEET

Note: Shaded/Bolded fields must be completed on individuals prior to Triage.
The remainder of the fields must be completed prior to opening an Episode.

*See Client Face Sheet Codes Table for a listing of codes/definitions for the field.
** Field is NOT entered into the IS; information gathering only.

CLIENT DATA		CLIENT I.D.#	
Last Name:			
First Name:		Middle Name:	
AKA/Maiden Last Name:			
AKA First Name:		Middle Name:	
SSN:		Mother's Maiden Name:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>		DOB:	Age:
English Speaking: Yes <input type="checkbox"/> No <input type="checkbox"/>		*Primary Lang:	*Preferred Lang:
*If Hispanic, Indicate Origin:		*If American Indian/Alaska Native, Indicate Tribe:	
*Education Level :	*Level of Care:	*Conservatorship:	
*Handicap:	*Marital Status:	*APR:	Veteran: Yes <input type="checkbox"/> No <input type="checkbox"/>
*Living Arrangement:	*Employment Status:	Date of Death:	
**Are there children in the home? Yes <input type="checkbox"/> No <input type="checkbox"/>		**Dependent(s) in the home? Yes <input type="checkbox"/> No <input type="checkbox"/>	
**Insurance: Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Indigent <input type="checkbox"/> Private/Other <input type="checkbox"/> Unknown <input type="checkbox"/>			
CLIENT ADDRESS			
Transient/Homeless: Yes <input type="checkbox"/> No <input type="checkbox"/> *Time Homeless:			
Address:			
Second Line:			
City:	*State:	Zip:	*County:
Phone (Home):	** (Cell)	(Work)	
Address Memo:			
EMERGENCY CONTACTS		DO NOT CONTACT EMERGENCY CONTACTS EXCEPT IN EMERGENCY SITUATIONS WHICH HAVE BEEN CLEARLY DOCUMENTED	
Name:		*Contact Type:	
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	
Name:		*Contact Type:	
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	
Complete only if the Client's Child is enrolled in FSP			
Child's Name:		Contact Type: Child Enrolled in FSP	
Address:	City:	State:	Zip:
DMH I.D.#	Phone:	Email:	
SFPR and PRIMARY CONTACT			
SFPR Name:		Provider Number:	
Primary Contact Name:		Provider Number:	
BIRTH INFORMATION			
Indicate Client Birth Name (If different than the name listed in Client Data)			
Last Name:	First Name:	Middle Name:	
Birth County:	Birth State:	Birth Country (If born outside US):	
Mother's First Name:			
<small>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</small>			
Agency:		Provider #:	
Los Angeles County – Department of Mental Health			

CLIENT FACE SHEET

[illegible]

Los Angeles County – Department of Mental Health

TRANSFER OF SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)

☐ Intra-agency Transfer of SFPR

Existing SFPR Information:

Individual/Team/Position: _____ Rendering Provider #: _____
(If Individual)

New SFPR Information:

Individual/Team/Position: _____ Rendering Provider #: _____
(If Individual)

☐ Update Primary Therapist to the above New SFPR

☐ Inter-agency Transfer of SFPR

Form completed by: ☐ Existing SFPR ☐ New SFPR ☐ Other _____

Existing SFPR Information

Person authorizing transfer: _____ Title/Discipline: _____ Phone #: _____
Provider Name: _____ Provider #: _____

New SFPR Information

Individual/Team/Position: _____ Phone #: _____
Provider Name: _____ Rendering Provider #: _____
(If Individual) Provider #: _____

Transfer of Information

The following forms: ☐ Will be sent ☐ Have been sent ☐ Have been received ☐ Should be sent

☐ Assessment ☐ Client Care/Coordination Plan ☐ Discharge Summary
☐ Payor Financial Info. ☐ Other: _____ Date Sent/Received: _____

Person sent to/receiving forms: _____

Fax #: _____ Phone #: _____

Our agency has been in contact with the client and transferring SFPR and accepts SFPR responsibilities as stated in DMH Policy 202.31 "Single Fixed Point of Responsibility" and the LACDMH Organizational Provider's Manual.

Signature of New SFPR: _____ Date: _____

Data Entry: (to be completed by clerical staff)

Existing SFPR deleted in the IS by: _____ Deleted on: _____

New SFPR entered in the IS by: _____ Entered on: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.

Name: _____ IS#: _____
Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

TRANSFER OF SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
 CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328



Close Outpatient Episode

Outpatient		CLIENT I.D.#	
Last Name:			
First Name:		Middle:	
Discharge Date:			
Referral Out Code:			
Referral Out Provider:			
Legal Status:			

DIAGNOSIS				
AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V
			<input type="checkbox"/> 1. Primary Support Group	GAF/CGAS
			<input type="checkbox"/> 2. Social Environment	
			<input type="checkbox"/> 3. Educational	
			<input type="checkbox"/> 4. Occupational	
			<input type="checkbox"/> 5. Housing	
			<input type="checkbox"/> 6. Economic	
			<input type="checkbox"/> 7. Access to Health Care	
			<input type="checkbox"/> 8. Interaction with Legal System	
			<input type="checkbox"/> 9. Other Psychological/Environmental	
			<input type="checkbox"/> 10. Inadequate Information	
Primary:				
Secondary:				

Provider Name: _____

Provider Number: _____

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328



Open Outpatient Episode

Outpatient		CLIENT I.D.#	
Last Name:			
First Name:		Middle:	
Admit Date:			
Other Factors:	Physical? Yes <input type="checkbox"/> No <input type="checkbox"/> DD? Yes <input type="checkbox"/> No <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/>		
Intent of Service:	<input type="checkbox"/> Assessment <input type="checkbox"/> Improvement <input type="checkbox"/> Maintenance		
Primary Problem Area:			
Referral In Code:		Legal Status:	
Referral In Reporting Unit:			
Treatment Authorization for Minor:			
Patient File #:			
Primary Contact:			
Service Plan Due Date:			
Coord Due Date:			

DIAGNOSIS

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V
			<input type="checkbox"/> 1. Primary Support Group	GAF/CGAS
			<input type="checkbox"/> 2. Social Environment	
			<input type="checkbox"/> 3. Educational	
			<input type="checkbox"/> 4. Occupational	
			<input type="checkbox"/> 5. Housing	
			<input type="checkbox"/> 6. Economic	
			<input type="checkbox"/> 7. Access to Health Care	
			<input type="checkbox"/> 8. Interaction with Legal System	
			<input type="checkbox"/> 9. Other Psychological/Environmental	
			<input type="checkbox"/> 10. Inadequate Information	
Primary:				
Secondary:				

Provider Name: _____

Provider Number: _____

**LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYER FINANCIAL INFORMATION**

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1 CLIENT NAME	SS #	DMH CLIENT ID #
2 MAIDEN NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP
SPOUSE NAME		

THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER <input type="checkbox"/>							
4 MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-CAL COUNTY CODE / AID CODE / CIN #		MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE REFERRED	
				REFERRED FOR ELIGIBILITY ASSESSMENT <input type="checkbox"/> YES <input type="checkbox"/> NO			
5 SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE		IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON		
6 CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES CIN #		AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 CONSENT FORM SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO	
7 MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY WAY LA <input type="checkbox"/> YES <input type="checkbox"/> NO	HWLA MEMBER #
8 HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED		
9 CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10 NAME OF PAYER		RELATION TO CLIENT	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	PAYER CDL/CAL ID
11 ADDRESS		CITY	STATE	ZIP CODE	TEL #
12 SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____					PAYER SS #
13 EMPLOYER		POSITION			IF NOT EMPLOYED, DATE LAST WORKED
14 EMPLOYER'S ADDRESS (Include City, State & Zip Code)					TEL #
15 SPOUSE		ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16 SPOUSE'S EMPLOYER		POSITION			IF NOT EMPLOYED, DATE LAST WORKED
17 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)					TEL #
18 NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)			TEL #

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS Savings \$ _____ Checking Accounts \$ _____ IRA, CD, Market value of stocks, bonds and mutual funds \$ _____ TOTAL LIQUID ASSETS \$ _____ Less Asset Allowance \$ _____ Net Asset Valuation \$ _____ Monthly Asset Valuation (Divide Net Asset by 12) \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	20 ALLOWABLE EXPENSES Court ordered obligations paid monthly \$ _____ Monthly child care payments (necessary for employment) \$ _____ Monthly dependent support payments \$ _____ Monthly medical expense payments \$ _____ Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____ Total Allowable Expenses \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	21 ADJUSTED MONTHLY INCOME Gross Monthly Family Income Self/Payer \$ _____ Spouse \$ _____ Other \$ _____ TOTAL HOUSEHOLD INCOME \$ _____ TOTAL FROM BOX 19 \$ _____+ SUBTOTAL \$ _____ LESS TOTAL FROM BOX 20 \$ _____- Adjusted Monthly Income \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	
22 Number Dependent on Adjusted Monthly Income (Client Included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM TO	Payment Plan \$ _____ per month for 1 2 3 4 5 6 months.
23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24 PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26 An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER			PROVIDER NAME AND NUMBER
27 I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON			DATE

CONSENT FOR SERVICES **INFORMATION ONLY**

The undersigned client* or responsible adult** consents to and authorizes mental health services by:

Name of Facility and/or Program

These services may include psychological testing, psychotherapy/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at a different location, services provided within the Los Angeles County mental health system will be coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has a right to be informed of and participate in the selection of any of the above services provided.
2. He/she has a right to receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
3. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or withdraw this consent at any time.
4. All personnel of the agency, as a condition of their employment, annually sign an oath of confidentiality which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures.
5. Any information disclosed to staff which is determined by them to be important to care, will be recorded in the clinical record to ensure treatment staff have available to them the most complete information about the client when deciding on treatment appropriate to the client's needs and for quality of care.
6. All client names are entered into a computer-based Information System that identifies the program(s) that is/are providing services to the client. This information is available without client authorization to any workforce member of the Department's directly-operated or contract service agency system.
7. Information from a client's clinical record relative to service delivery needs may be shared within this agency and within the Los Angeles County mental health system (directly-operated and contract agencies) without obtaining the authorization of the client.

Signature of Client*

Date

Signature of Responsible Adult**

Relationship to Client

Date

Signature of Witness/Interpreter ***

Date

This Consent was interpreted in _____ for the client and/or responsible adult.

If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ by _____
Date Initials

This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.

- ☐ Client is willing to accept services, but unwilling to sign this Consent.
- ☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent.

Signature of Staff

Date

- * A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
- ** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
- *** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County – Department of Mental Health

CONSENT FOR SERVICES

CONSENT TO PHOTOGRAPH / AUDIO RECORD

INFORMATION ONLY

The undersigned client* or responsible adult** consents to: _____ to

Name of Facility and/or Program or Unit and/or Employee Name

☐ Photograph (which, as used in this Consent, means motion picture, still photography in any form, videotapes, or any other mechanical means of recording and reproducing images)

☐ Audio record

The undersigned:

1. Agrees that photographs/audio recordings made as a result of this consent will be used for purposes of:

☐ Learning and training purposes

☐ Client Identification

☐ Research (Approval of Department Human Subjects Committee required)

☐ Publication, public relations, webpages and/or fund-raising (MH 602 Authorization required)

☐ Sharing Recovery Stories (MH 677 Authorization required which must be obtained from the Clinical Records Director for the specific purpose and modality in which the stories will be shared)

2. Waives any right to compensation for use of the photographs/audio recordings;

3. Holds the Department harmless from and against any claim of injury or compensation resulting from the activities authorized by this Consent.

Signature of Client*

Date

Signature of Responsible Adult**

Relationship to Client

Date

Signature of Witness/Interpreter ***

Date

This Consent was interpreted in _____ for the client and/or responsible adult.

If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ by _____
Date Initials

This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.

☐ Client is willing to consent to photograph/audio record, but unwilling to sign this Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent.

Signature of Staff

Date

* A minor client receiving services under his/her own signature must have the signed Minor Consent and a Consent for Service form on file in the clinical record.

** Responsible Adult = Guardian, Conservator, or Parent of minor when required.

*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

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Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County – Department of Mental Health

CONSENT TO PHOTOGRAPH / AUDIO RECORD

CONSENT FOR TELEMENTAL HEALTH SERVICES

INFORMATION ONLY

Page 1 of 2

I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The potential benefit of Telemental health services is that I will be able to talk with mental health staff today from this local setting for an evaluation of my needs. When appropriate, I will be able to participate in mental health services, start on medication today, or continue my current medications uninterrupted.
3. The potential risk of Telemental health services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process.
4. There is no permanent video or voice recording kept of the Telemental health service's session.
5. All existing confidentiality protections apply.
6. All existing laws regarding client access to mental health information and copies of mental health records apply.
7. Dissemination of client identifiable images or information from the Telemental health interaction to researchers or other entities shall not occur without the consent of the client.

I, _____, consent to Telemental health services in circumstances in which mental health staff appropriate to my needs is not immediately available at my site. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

Signature of Client*

Date

Signature of Responsible Adult**

Relationship to Client

Date

Signature of Witness/Interpreter ***

Date

This Consent was interpreted in _____ for the client and/or responsible adult.

If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ by _____
Date Initials

This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.

- ☐ Client is willing to accept Telemental health services, but unwilling to sign this Consent.
- ☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent and I affirm the client meets all eligibility criteria as noted on the Consent of Minor form to receive medication without legal representative consent.

Signature of Staff

Date

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.

** Responsible Adult = Guardian, Conservator, or Parent of minor when required.

*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

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Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County - Department of Mental Health

CONSENT FOR TELEMENTAL HEALTH SERVICES

Telemental Health Services Information

INFORMATION ONLY

What are Telemental health services and when are they used?

Telemental health services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telemental health services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

How do Telemental health services work?

You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, clinic staff will start the computer and camera so that you and mental health staff can see each other and talk together. When the session is over, clinic staff will shut off the equipment.

How is it different than a regular session with mental health staff?

Other than you and mental health staff not being in a room together, there is very little difference in the session. Mental health staff will ask and document clinical information that you share with him/her, send any prescriptions that are ordered to the pharmacy for you to pick up if medications are prescribed, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

What happens if I choose not to consent to Telemental health services?

If you choose not to consent to Telemental health services, we will be unable to provide you with convenient and readily available services and your services will be rescheduled for a later date and/or a different site.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

IS#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

ADVANCE HEALTH CARE DIRECTIVE ACKNOWLEDGEMENT FORM

INFORMATION ONLY

Background

In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directives and be informed of their right to make decisions about their medical treatment.

To Be Completed by Staff

The client was given a copy of the Advance Health Care Directive Fact Sheet at the first face-to-face contact or clinic visit.

☐ Yes ☐ No

If "No" please explain why the client was not given the Fact Sheet:

Does the client have an Advance Health Care Directive currently in place?

☐ Yes ☐ No

If the client would like to execute an Advance Health Care Directive, please refer them to the resources identified on the Fact Sheet. If a client already has an Advance Health Care Directive, insert a copy into the client's Clinical Record in Section 2 (Consents and Notices).

To Be Completed by the Client/Responsible Adult*

I have been asked about having an Advance Health Care Directive, and I have been given or offered an Advance Health Care Directive Fact Sheet.

Signature of Client

Date

Signature of Responsible Adult*

Relationship to Client

Date

Signature of Witness/Interpreter **

Date

This Form was interpreted in _____ for the client and/or responsible adult.

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Form on _____ by _____
Date Initials

* Responsible Adult = Guardian, Conservator, or Parent of minor when required.

** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County - Department of Mental Health

ADVANCE HEALTH CARE DIRECTIVE

ADVANCE HEALTH CARE DIRECTIVE FACT SHEET

What is an Advance Health Care Directive?

An Advance Directive is a legal document that allows an individual to state in advance their wishes should they become unable to make healthcare decisions.

In California, an Advance Directive consists of two parts:

(1) appointment of an agent for healthcare; and (2) individual health care instructions.

What can an Advance Health Care Directive do for a person with a psychiatric disability?

- It allows you to make treatment choices now in the event you need mental health treatment in the future. You can tell your doctor, institution, provider, treatment facility, and judge what types of treatment you do and do not want.
- You can select a friend or family member to make mental health care decisions, if you cannot make them for yourself.
- It can improve communications between you and your physician.
- It may reduce the need for long hospital stays.
- It becomes a part of your medical record.

Who can fill out an Advance Health Care Directive?

Any person 18 years or older who has the "capacity" to make health care decisions. "Capacity" means the person understands the nature and consequences of the proposed healthcare, including the risks and benefits.

When does an Advance Health Care Directive go into effect?

An Advance Health Care Directive goes into effect when the person's primary physician decides the person does not have the "capacity" to make their own healthcare decisions. This means the individual is unable to understand the nature and consequences of the proposed healthcare. *The fact that a person has been admitted into a psychiatric facility does not mean the person lacks "capacity."*

How long is an Advance Health Care Directive in effect?

In California, an Advance Health Care Directive is indefinite. You can change your mind at any time, as long as you have the "capacity" to make decisions. It is a good idea to review your Advance Health Care Directive yearly to make sure your wishes are stated.

Do I have to have an Advance Health Care Directive?

No. It is just a way of making your wishes known in writing, while you are capable. Your choices are important.

Where do I get legal advice about an Advance Health Care Directive?

- Your Attorney
- Protection and Advocacy, Inc.
- Mental Health America of Los Angeles (213) 413-1130, Ext. 26

Where can I get the Advance Health Care Directive Forms?

- Your Attorney
- Stationary Stores
- Mental Health America of Los Angeles (213) 413-1130, Ext. 26

Who should have a copy of the Advance Health Care Directive?

- You (Your Advance Health Care Directive should be kept in a safe place, but easily accessible.)
- Your agent (the person designated to make health care decisions if you are unable to do so.)
- Each of your health care providers;
- Each of your mental health providers.

It is important that you keep track of who has a copy of your Advance Health Care Directive in case you make changes in the document.

Complaints concerning non-compliance with the advance health care directive requirements may be filed with the California Department of Health Services (DHS) Licensing and Certification by calling 1-800-236-9747 or by mailing to P.O. Box 997413, Sacramento, California 95899-7413.

ADVANCE HEALTH CARE DIRECTIVE FACT SHEET

LACDMH NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County Department of Mental Health (LACDMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at <http://www.dmh.co.la.ca.us> or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LACDMH.

Signature: _____
(client/parent/conservator/guardian)

Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member: _____ Date: _____

Reasons why the acknowledgement was not obtained:

☐ Client refused to sign (see progress notes for explanation)

☐ Other Reason or Comments:

INFORMATION ONLY*Effective Date: April 14, 2003*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

This Notice describes LACDMH practices and that of:

- All employees, staff and other LACDMH personnel.
- Any member of a volunteer group we allow to help you while you are in the facility.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the facility. As required and when appropriate, we will ensure that the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

Keep your medical information, also known as "protected health information" or "PHI," private;

Give you this Notice of our legal duties and privacy practices with respect to your PHI; and

Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We create a record of the treatment and services you receive at our facilities. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some

medications affect your blood pressure. We may share your PHI in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

We also may disclose your PHI to people outside the facility who may be involved in your treatment, such as your case manager, or other persons for coordination and management of your health care. Your mental health information may only be released to health care professionals outside this facility without your authorization if they are responsible for your physical or mental health care.

For Payment

We may use and disclose your PHI in order to get paid for the treatment and services we have provided you. For example, we may need to give your health plan information about a medication, visit, or treatment session you received at the facility so your health plan will pay us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose your PHI to carry out activities that are necessary to run our facilities and to make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility clients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and learning purposes.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you (for example, Medi-Cal eligibility or Social Security benefits).

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our professional judgment to decide whether this disclosure is in your best interest.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU THAT DO NOT REQUIRE YOUR AUTHORIZATION

Research

We may disclose your PHI to medical researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers who will be required to safeguard the PHI they receive.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

Workers' Compensation

We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the PHI requested.

Law Enforcement

We may disclose PHI to government law enforcement agencies in the following circumstances:

- In response to a court order, warrant, subpoena, summons or similar process issued by a court.
- If a psychotherapist believes that it is likely that you present a serious danger of violence to another person.
- To report your discharge, if you were involuntarily detained after a peace officer initiated a 72-hour hold for evaluation and requested notification.

In certain circumstances, if you have been admitted to a facility and have disappeared or been transferred.

Coroners, Medical Examiners and Funeral Directors

We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about clients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions

We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Your Medical Information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you.

RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI from our records. Usually, this includes treatment and billing records.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your case manager or the person in charge of your treatment. A form will be provided to you for this request. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within LACDMH, who was not involved in the denial, will review the decision. We will comply with the outcome of the review.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI.

To request an amendment, ask for a "Request to Amend Protected Health Information" form, and complete and submit this form to your case manager or the person in charge of your treatment. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend PHI that:

Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;

Is not part of the PHI kept by or for the facility;

Is not part of the PHI which you would be permitted to inspect and copy; or

Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a Statement of Disagreement form, with a description not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, ask for a "Request for an Accounting of Disclosures" form, and complete and submit this form to your case manager or the person in charge of your treatment. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at this facility.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, ask for a "Request for Additional Restrictions on Use or Disclosure of Protected Health Information," and complete and submit this form to your case manager or the person in charge of your treatment. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, ask for a "Request to Receive Confidential Communications by Alternative Means or at Alternative Locations" form, and complete and submit this form to your case manager or to the person in charge of your treatment. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website: <http://www.dmh.co.la.ca.us/>

To obtain a paper copy of this Notice, please contact your Treatment Team.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at <http://www.dmh.co.la.ca.us/> or you may request one from your Treatment Team.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact:

**Los Angeles County Department of Mental Health (LACDMH)
Patient's Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949**

To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office (LACCIO)
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102.
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**

INFORMATION ONLY

NOTIFICACIÓN DE NORMAS DE CONFIDENCIALIDAD O PRIVACIDAD DEL DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE LOS ANGELES (LACDMH):

Comprobante de recibo

Vigencia: 14 de abril de 2003

COMPROBANTE DE RECIBO

Con la firma de este formulario, usted confirma haber recibido la *Notificación de Normas de Confidencialidad o Privacidad* del Departamento de Salud Mental del Condado de Los Angeles (LACDMH, por sus siglas en inglés). En nuestra *Notificación de Normas de Confidencialidad* se proporciona información sobre la manera en que podremos usar y revelar su información médica protegida. Le invitamos a que la revise cuidadosamente.

Nuestra *Notificación de Normas de Confidencialidad* está sujeta a cambios. Si hacemos cambios a nuestra Notificación, usted podrá obtener una copia de la Notificación revisada si visita nuestro sitio en la red <http://www.dmh.co.la.ca.us/> o si la solicita a nuestro Equipo de Tratamiento.

Confirmando haber recibido la *Notificación de Normas de Confidencialidad* del LACDMH.

Firma: _____
(Cliente/padre o madre/"conservador" o curador/tutor)

Fecha: _____

INCAPACIDAD PARA CONSEGUIR EL COMPROBANTE DE RECIBO

Llenar únicamente si no se obtiene la firma. Si no es posible conseguir el comprobante de recibo de la persona, describa los intentos de buena fe que se hayan hecho para obtener el comprobante de recibo del individuo y los motivos por los cuales no se pudo conseguir:

Firma del Miembro del Equipo de Tratamiento: _____ Fecha: _____

Motivos por los cuales no se pudo obtener el comprobante de recibo:

- ☐ El Cliente se negó a firmar (ver la explicación en las notas de progreso)
- ☐ Otro motivo o comentarios:

INFORMATION ONLY

NOTIFICACIÓN DE NORMAS DE CONFIDENCIALIDAD O PRIVACIDAD DEL DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE LOS ANGELES (LACDMH):

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Confirmando haber recibido la *Notificación de Normas de Confidencialidad* del LACDMH.

Firma: _____
(Cliente/padre o madre/"conservador" o curador/tutor)

Fecha: _____

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Firma del Miembro del Equipo de Tratamiento: _____ Fecha: _____

Motivos por los cuales no se pudo obtener el comprobante de recibo:

- ☐ El Cliente se negó a firmar (ver la explicación en las notas de progreso)
- ☐ Otro motivo o comentarios:

INFORMATION ONLY

Vigencia: 14 de abril de 2003

EN ESTA NOTIFICACIÓN SE DESCRIBE LA MANERA EN LA QUE SE PODRÁ USAR Y REVELAR LA INFORMACIÓN MÉDICA SOBRE USTED, Y LA FORMA EN QUE USTED PUEDE TENER ACCESO A ESTA INFORMACIÓN. REVÍSELA CUIDADOSAMENTE.

QUIÉN SEGUIRÁ LAS NORMAS DE ESTA NOTIFICACIÓN

En esta Notificación se describen las normas del LACDMH y las de:

- Todos los empleados y demás miembros del personal del LACDMH.
- Cualquier miembro de un grupo de voluntarios al que permitimos que le ayude mientras usted está en las instalaciones*.

NUESTRA PROMESA SOBRE SU INFORMACIÓN MÉDICA

Entendemos que la información médica sobre usted y su salud es personal. Tenemos el compromiso de proteger su información médica. Creamos un expediente de la atención y los servicios que recibe en las instalaciones. Necesitamos estos registros para ofrecerle atención de calidad y cumplir con determinados requisitos legales. Esta Notificación se aplica a todos los registros sobre su atención que se generen en las instalaciones. Cuando se requiera y sea apropiado, nos aseguraremos de que en el desempeño de nuestras obligaciones se revele el mínimo necesario de información.

En esta Notificación se le informará sobre las maneras en las que podremos usar y revelar su información médica. También se describen sus derechos y determinadas obligaciones sobre el uso y la revelación de información médica.

De acuerdo con la ley se requiere que:

Mantengamos la confidencialidad de su información médica. Esta información se conoce también como "información médica protegida" ("PHI", por sus siglas en inglés);

Le entreguemos esta Notificación de nuestras obligaciones legales y normas de confidencialidad con respecto a su PHI; y

Respetemos los términos de la Notificación que está actualmente vigente.

CÓMO PODREMOS USAR Y REVELAR SU INFORMACIÓN MÉDICA PROTEGIDA

En las siguientes categorías se describen diferentes maneras en las que usamos y revelamos información médica protegida. En cada una de las categorías de los usos o la revelación de datos, explicaremos lo que significan y trataremos de darle algunos ejemplos. No se listan todos los usos o revelación de información de la categoría; sin embargo, todas las formas en que se nos permita usar y revelar información caen dentro de una de las categorías.

* "Instalaciones" se refiere a la clínica, hospital o agencia encargada de prestar servicios/tratamiento al cliente.

Para tratamiento

Crearemos un registro del tratamiento y los servicios que usted recibe en nuestras instalaciones. Podremos usar su PHI para proporcionarle tratamiento o servicios médicos. Podremos revelar su PHI a los médicos, enfermeras, técnicos, estudiantes de medicina u otro personal que le atiendan en las instalaciones. Por ejemplo, es posible que un médico que le esté atendiendo por un desequilibrio químico necesite saber si usted tiene problemas del corazón porque algunos medicamentos afectan la tensión arterial. Es posible que compartamos su PHI para poder coordinar las diferentes cosas que necesite, como recetas, exámenes de tensión arterial, análisis de laboratorio, y para poder determinar un diagnóstico correcto.

También podremos revelar su PHI a personas fuera de las instalaciones que puedan estar implicadas en su tratamiento, como el administrador de su caso u otras personas, con el fin de coordinar y administrar su atención médica. Información de su salud mental sólo se podrá revelar, sin su autorización, a profesionales de atención médica fuera de estas instalaciones si ellos son los responsables de su atención médica física o mental.

Para pagos

Podremos usar y revelar su PHI con el fin de obtener pago por el tratamiento y los servicios que le prestemos. Por ejemplo, es posible que necesitemos dar a su plan de salud información sobre un medicamento, visita o sesión de tratamiento que usted haya recibido en las instalaciones con el fin de que nos pague su plan de salud. También podremos informar a su plan de salud sobre un tratamiento que usted vaya a recibir a fin de obtener aprobación previa o de determinar si su plan cubrirá el costo del tratamiento.

Para operaciones de atención médica

Podremos usar y revelar su PHI con el fin de poder realizar las actividades necesarias para administrar nuestras instalaciones y asegurarnos de que todos nuestros clientes reciben atención de calidad. Por ejemplo, podremos usar información médica para revisar nuestro tratamiento y servicios, además de evaluar el desempeño de nuestro personal cuando le atienden. Es posible que también combinemos información médica de muchos clientes de las instalaciones con el fin de decidir qué servicios adicionales deben ofrecer las instalaciones, qué servicios no se necesitan y la eficacia de algunos tratamientos nuevos. También podremos revelar información a médicos, enfermeras, técnicos, estudiantes de medicina y otro personal de la instalación para revisiones y con fines educativos.

Recordatorios de citas

Podremos usar y revelar su PHI con el fin de ponernos en contacto con usted y recordarle que tiene una cita para recibir tratamiento o atención médica en las instalaciones.

Alternativas de tratamiento, y productos y servicios relacionados con la salud

Podremos usar y revelar su PHI con el fin de recomendar opciones o alternativas posibles de tratamiento que quizá le interesen. Asimismo, podremos usar y revelar su PHI con el fin de informarle de beneficios o servicios relacionados con la salud que quizá le interesen (por ejemplo, elegibilidad para Medi-Cal o beneficios del Seguro Social).

Personas implicadas en prestarle atención o en pagar por la atención que usted reciba

Podremos revelar su PHI a un amigo o familiar que esté implicado en su atención médica o en el pago relacionado con su atención médica, siempre que usted esté de acuerdo en que se revele la información o que le demos la oportunidad de oponerse a que se revele la información. Sin embargo, si usted no está disponible o no puede indicar si está de acuerdo o no, usaremos nuestro criterio profesional para decidir si esta revelación de la información es conveniente para usted.

Para ayuda en caso de desastre

Podremos revelar su PHI a un organismo que ayude en caso de desastre a fin de que se pueda notificar a su familia sobre su condición, situación y ubicación. Le daremos la oportunidad de que dé o niegue su autorización para revelar la información, excepto si decidimos que necesitamos revelar su PHI para poder responder a una emergencia.

USO Y REVELACIÓN DE SU INFORMACIÓN MÉDICA EN CASOS QUE NO REQUIEREN SU AUTORIZACIÓN

Investigación científica

Podremos revelar su PHI a los investigadores médicos que la soliciten para proyectos de investigación médica aprobados; sin embargo, dicha revelación de la información deberá realizarse por medio de un proceso especial de autorización previa a la entrega de la PHI a los investigadores, a quienes se les requerirá que protejan la PHI que reciban.

Conforme se requiera por ley

Revelaremos su PHI cuando se requiera hacerlo conforme a las leyes federales, estatales o locales.

Compensación del seguro obrero (Workers' Compensation)

Podremos entregar su PHI en los casos de compensación del seguro obrero o programas similares. Estos programas ofrecen beneficios para lesiones o enfermedades relacionadas con el trabajo.

Riesgos para la salud pública

Podremos revelar su información médica para actividades relacionadas con la salud pública, como las que tienen como objetivo prevenir o controlar enfermedades, prevenir lesiones o discapacidades y reportar el maltrato o abandono de niños, ancianos y adultos dependientes.

Actividades para la supervisión de la salud

Podremos revelar su PHI a una agencia supervisora de la salud para actividades autorizadas por ley, por ejemplo, auditorías, investigaciones, inspecciones, y concesión de licencias. Estas actividades son necesarias para que el gobierno supervise el sistema de salud, los programas gubernamentales y el cumplimiento de las leyes de derechos civiles.

Demandas y disputas

Si usted está involucrado en una demanda o en una disputa, podremos revelar su PHI si recibimos una orden judicial o administrativa. Podremos revelar también su PHI si recibimos una citación judicial, solicitud de entrega de pruebas o algún otro procedimiento legal por parte de un tercero implicado en la disputa, pero sólo si se trató de informarle a usted sobre dicha solicitud (que puede incluir notificarle por escrito) o de obtener una orden para proteger la PHI que se solicita.

Organismos encargados del cumplimiento de la ley

Podremos revelar la PHI a las agencias gubernamentales encargadas del cumplimiento de la ley en los siguientes casos:

- En respuesta a órdenes judiciales, citaciones judiciales o procedimientos semejantes que dicte un tribunal.
- Si un psicoterapeuta cree que es probable que usted represente un peligro grave de violencia en contra de un tercero.
- Para reportar que se le ha dado de alta, si se le detuvo involuntariamente después de que un policía inició una orden de detención de 72 horas para una evaluación y solicitó notificación.
- En determinadas circunstancias, si se le admitió en unas instalaciones y usted ha desaparecido o ha sido transferido a otro lado.

Médicos forenses, examinadores médicos y directores de funerarias

Podremos entregar la PHI a un médico forense o a un examinador médico. Esto puede ser necesario, por ejemplo, para identificar a una persona que ha fallecido o para determinar la causa de la muerte. También podremos revelar información médica sobre clientes de las instalaciones a un director de una funeraria según sea necesario para que desempeñe su trabajo.

Funciones especializadas del gobierno

Podremos revelar su PHI a agentes federales autorizados para usarla en actividades de inteligencia, contrainteligencia y otras operaciones de seguridad nacional autorizadas por ley.

Podremos revelar su PHI a agentes federales autorizados para que puedan proporcionar protección al Presidente de los Estados Unidos, otras personas autorizadas o jefes de estado extranjeros, o para realizar investigaciones especiales.

Presos o detenidos

Si está preso o un agente encargado del cumplimiento de la ley lo tiene detenido, podremos entregar su PHI a la correccional o a dicho agente. Esta revelación de información sería necesaria: 1) para que la institución le preste atención médica; 2) para proteger su propia salud y seguridad o las de otras personas; o 3) para la seguridad y protección de la correccional.

Otros usos de su información médica

Sólo se usará y revelará su PHI con su autorización por escrito en los casos que no se cubran en esta Notificación o las leyes correspondientes. Si nos da su autorización para usar o revelar su PHI, la podrá revocar por escrito en cualquier momento. Si la revoca, ya no podremos usar ni revelar su PHI en los casos que cubre la autorización, excepto que no podremos recuperar la información que hayamos revelado mientras la autorización estuvo en vigencia, y estamos obligados a mantener los registros de la atención que le hemos proporcionado con anterioridad.

DERECHOS RELACIONADOS CON SU PHI

Usted tiene los siguientes derechos con respecto a su PHI en nuestros registros:

Derecho a revisar y copiar información

Con excepción de algunos casos, usted tiene derecho a revisar y copiar su PHI que tenemos en nuestros registros, en la cual se incluyen generalmente los registros de tratamiento y facturación.

Si desea revisar y copiar la PHI que se pueda usar para tomar decisiones sobre usted, deberá entregar su solicitud por escrito al administrador de su caso o a la persona encargada de su tratamiento. Se le proporcionará un formulario para que haga esta solicitud. Si solicita una copia de su PHI, es posible que le cobremos por los costos de hacer copias, el envío por correo y otros gastos relacionados con su solicitud.

En determinadas circunstancias podremos rechazar su solicitud para revisar y copiar la información. Si se le niega el derecho a revisar y copiar su PHI que tenemos en nuestros registros, podrá solicitar que se revise la denegación. Excepto por las pocas circunstancias que no están sujetas a revisión, personal profesional autorizado por LACDMH, que no esté implicado en la denegación, revisará la decisión. Cumpliremos con los resultados de la revisión.

Derecho a solicitar enmiendas

Si piensa que la PHI sobre usted que tenemos en nuestros registros es incorrecta o no está completa, puede pedirnos que enmendemos la información. Usted tiene derecho a solicitar enmiendas durante todo el tiempo que tengamos la PHI.

Si desea solicitar una enmienda, pida una "Solicitud para enmendar información médica protegida" (*"Request to Amend Protected Health Information"*), llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. Debe explicar por escrito los motivos que respaldan su solicitud.

Podremos rechazar su solicitud para hacer una enmienda si no la presenta por escrito o no incluye un motivo que respalde la solicitud. También podremos rechazar su solicitud si nos pide que enmendemos una PHI que:

No hayamos creado nosotros, excepto si nos puede proporcionar una base razonable para creer que la persona o entidad que haya creado la PHI ya no está disponible para efectuar la enmienda;

No es parte de la PHI que mantienen las instalaciones para su uso;

No es parte de la PHI que se le permitiría revisar y copiar; o

Es exacta y completa.

Aunque le rechazemos su solicitud para efectuar una enmienda, usted tiene derecho a presentar una "Declaración de Desacuerdo" (*"Statement of Disagreement"*) con una descripción de un máximo de 250 palabras sobre cualquier punto o declaración en su registro que usted crea que esté incompleta o sea incorrecta. Si usted indica claramente por escrito que desea que esta declaración pase a formar parte de su registro médico, la adjuntaremos a su registro y la incluiremos siempre que demos información del punto o la declaración que usted piensa que está incompleta o incorrecta.

Derecho a recibir una relación de casos de revelación de información

Tiene derecho a solicitar una lista de los casos en los que se haya revelado su PHI para fines ajenos a nuestras actividades de tratamiento, pago y atención médica (según se describen previamente) y otras excepciones según se estipulan en la ley.

Si desea solicitar esta lista o la relación de los casos en que se reveló información, pida una "Solicitud de una relación de casos de revelación de información" (*"Request for an Accounting of Disclosures"*), llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud se deberá indicar un período que no podrá ser mayor de seis años y no podrá incluir fechas antes del 14 de abril de 2003. Recibirá gratis la primera lista que solicite en un período de 12 meses. Podremos cobrarle por el costo de listas adicionales. Le informaremos cuál es el costo y usted podrá optar por retirar o modificar su solicitud en ese momento antes de que se incurra en dicho costo.

Derecho a solicitar restricciones

Tiene derecho a solicitar que se apliquen restricciones especiales adicionales cuando se use o revele su PHI para actividades de tratamiento, pago o atención médica. También tiene derecho a solicitar que sigamos las restricciones especiales adicionales cuando usemos o revelemos su PHI a una persona, por ejemplo un familiar o un amigo, que esté implicada en prestarle atención o en el pago de su atención médica. Por ejemplo, puede pedirnos que no usemos ni revelemos información de que usted está recibiendo servicios en estas instalaciones.

No estamos obligados a estar de acuerdo con su solicitud. Si estamos de acuerdo, cumpliremos con su solicitud, excepto si se necesita la información para proporcionarle un tratamiento de emergencia.

Si desea pedir que se apliquen restricciones, pida una "Solicitud para restricciones adicionales en el uso o la revelación de información médica protegida" (*"Request for Additional Restrictions on Use or Disclosure of Protected Health Information"*), llénela y

entreguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud deberá decirnos: 1) cuál información desea restringir; 2) si desea limitar nuestro uso de la información, la revelación de la misma o ambos; y 3) a quién desea que se apliquen las restricciones (revelar información a su cónyuge, por ejemplo).

Derecho a solicitar que le demos información en forma confidencial

Tiene derecho a solicitar que nos comuniquemos con usted sobre sus citas u otros asuntos relacionados con su tratamiento de una manera específica o en un lugar determinado. Por ejemplo, puede pedir que sólo nos pongamos en contacto con usted en su trabajo o por correo.

Si desea solicitar que le demos información en forma confidencial, pida una "Solicitud para recibir información en forma confidencial por medios alternos o en sitios alternos" (*"Request to Receive Confidential Communications by Alternative Means or at Alternative Locations"*). Llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud se debe especificar la manera o el lugar en donde desea que nos pongamos en contacto con usted. No le preguntaremos el motivo de su solicitud. Haremos los arreglos apropiados para todas las solicitudes razonables.

Derecho a recibir una copia impresa de esta Notificación

Tiene derecho a recibir una copia impresa de esta Notificación. En cualquier momento puede solicitar que le demos una copia de esta Notificación. Aunque usted haya estado de acuerdo en recibir esta Notificación electrónicamente, de todas formas tiene derecho a recibir una copia impresa de la Notificación.

Puede obtener una copia de esta Notificación en nuestro sitio en la red:

<http://www.dmh.co.la.ca.us/>

Si desea obtener una copia impresa de esta Notificación, póngase en contacto con su Equipo de Tratamiento.

CAMBIOS A ESTA NOTIFICACIÓN

Nos reservamos el derecho a cambiar los términos de esta Notificación, y a hacer que entre en vigencia la Notificación revisada o modificada en la información médica que ya tenemos sobre usted, además de cualquier información que recibamos en el futuro. Pondremos a la vista pública, en las instalaciones, una copia de la Notificación vigente, la cual contendrá la fecha de vigencia en la esquina superior derecha de la primera página. Si cambiamos nuestra Notificación, podrá obtener una copia de la Notificación revisada si visita nuestro sitio en la red en <http://www.dmh.co.la.ca.us/> o puede pedirla a su Equipo de Tratamiento.

QUEJAS

Si cree que no se han respetado sus derechos a la confidencialidad, puede presentar una queja con nosotros, con el Condado de Los Angeles o con el gobierno federal. Todas las quejas se deben presentar por escrito. No se le castigará ni sufrirá represalias por el hecho de presentar una queja. Si desea presentar una queja con nosotros, o si tiene comentarios o preguntas sobre nuestras normas de confidencialidad, comuníquese con:

Los Angeles County Department of Mental Health (LACDMH)

**Patient's Rights Division
(Oficina de Derechos del Paciente)
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949**

Si desea presentar una queja con el Condado de Los Angeles, comuníquese con:

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
(Oficial de Informática y Privacidad)
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Dirección electrónica: CIPO@cio.co.la.ca.us**

Si desea presentar una queja ante el gobierno federal, comuníquese con:

**Region IX, Office of Civil Rights
(Oficina de Derechos Civiles)
US Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

CLIENT'S REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name: _____

Date: _____

Date of Birth: _____

MIS #: _____

1. I understand that DMH may use or disclose my protected health information ("PHI") for the purposes and under the circumstances described in the DMH *Notice of Privacy Practices*, and that otherwise, DMH must not use or disclose my PHI.

2. I understand that I may request that DMH refrain from certain uses or disclosures of my PHI that the law would otherwise allow. Specifically, I understand that I may request that DMH refrain from using or disclosing my PHI for any of the following purposes:

- a. For my treatment;
- b. To obtain payment for services rendered to me;
- c. For its various "health care operations", as defined by federal law;
- d. If I do not object, to family members, individuals involved in my care or payment for my care; and
- e. If I do not object, to disaster relief agencies.

3. I also understand that even though I have the right to ask that DMH not make one or more of these disclosures, DMH does not have to agree to my request.

4. If you ask us to restrict our uses and disclosures of your PHI even more than the law requires, and if we agree to do so, we are required to honor that agreement. We will notify you in writing as to whether or not DMH will agree to or will deny your restriction request. Until a decision is made, we will continue to use and disclose your PHI as allowed or required by law.

5. I hereby request that DMH agree to limit its use or disclosure of my PHI as follows:

- a. The information I want to have specially protected is:



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

b. I want to limit:

- ☐ The inside use of this information by DMH (i.e., the communication of this PHI among DMH workforce personnel for otherwise lawful purposes).
- ☐ The outside disclosure of this information by DMH (i.e., the communication of this PHI to persons or organizations outside of DMH, for otherwise lawful purposes).
- ☐ Both the inside use and the outside disclosure of this information.

c. Complete, only if applicable: I do not want the following person/entity to receive the information described in paragraph 5.a above: _____

Signature of client or representative: _____

If representative, give relationship: _____

DENIAL OF REQUEST

Until further notice, as permitted by the federal Privacy Regulations, DMH will not be able to agree to your request for restriction.

Signature of Treatment Provider: _____

Date: _____



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

LETTER OF DENIAL REGARDING CLIENT'S
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

{Mr./Ms./Mrs. Client's Name}

{Client's Address}

{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your *CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS* form. DMH has reviewed your request to receive communications involving your health information from us through an alternative means or to an alternative location and has determined that it must deny your request.

Reason for Denial:

If you have any questions, please contact the Treatment Team or call us at {PHONE NUMBER}.

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}

Program/Unit Manager

Department of Mental Health

Los Angeles County



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Note: This form applies only to requests for confidential communications, i.e., when an individual is requesting a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify DMH of a change in address or other contact information.

Client Name: _____
Date of Birth: _____

Date: _____
MIS #: _____

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

Alternate Address (postal or email):

New Phone Number (include area code):

Indicate what method of communication NOT to use: _____

Signature of client or representative: _____

If representative, give relationship: _____

APPROVAL

Signature of Treatment Provider: _____

Date: _____

SECTION II



INFORMATION ONLY

DEPARTMENT OF MENTAL HEALTH

ACCOUNT TRACKING SHEET

NOTE: Consult with County Counsel prior to making any non-routine disclosures.

(See Accounting of Disclosure of PHI 2.4.1)

Date of Disclosure	Name and Address Of Entity Receiving PHI	Description of PHI Disclosed	Statement of Purpose of Disclosure

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ MIS#: _____

Facility/Practitioner: _____

Los Angeles County – Department of Mental Health

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE

For a Healthy Way L.A. Referral, provide the HWLA ID#: _____

Client Information

MRUN: _____

Name: _____

DOB: _____

Address: _____

Phone Number: _____

Referring Physician and Care Coordinator Information

Referring Physician: _____

Name of Clinic: _____

Care Coordinator Name & Title: _____

Phone Number: _____

Fax Number: _____

DMH Disposition

- ☐ Individual accepted for services
☐ Individual declined DMH services
☐ Unable to contact individual

☐ DMH services not indicated (If selecting this box, please be sure to include in General Findings the reason DMH services are not indicated at this time, along with any recommended linkage information.)

General Findings (include additional areas of identified need):

Mental Health Diagnosis(es):

Psychotropic medications prescribed by DMH:

Treatment Plan Overview (include planned treatment interventions; if barriers or complications are a focus of concern include below):

Service Area Navigator Information

DMH SA Navigator: _____

Phone Number: _____

Fax Number: _____

Responding Provider Information

Print Name & Title of Responding Provider: _____

Signature: _____

Date: _____

Time: _____

Name of DMH Clinic: _____

Telephone #: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County – Department of Mental Health

DMH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Original Copy – To Agency Initiating Referral
NCR Copy – Retained by DMH Program

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Purpose: This form is for the use of DMH Staff when responding to referrals of non-emergency clients by Primary Care Providers (PCP).

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

DEPARTMENT OF MENTAL HEALTH REFERRAL

For a Healthy Way L.A. Referral, provide the HWLA ID#:

Patient Information (PLEASE ATTACH PATIENT FACE SHEET if available)

MRUN:

Name:

DOB:

Address:

Phone Number:

Preferred Language:

Special Needs (Wheel Chair, Translator, Hearing, Sight):

Medical Diagnosis(es):

Psychiatric Diagnoses (if known):

Name of Screening Tool (Indicate which screening tool used and attach to Referral Form)	Score (if previously administered)	Date of Administration
<input type="checkbox"/> PHQ 2 <input type="checkbox"/> PHQ 4 or <input type="checkbox"/> PHQ 9		
<input type="checkbox"/> Other: <input type="text"/>		

Current Physical Health/Psychotropic Medication(s) (if available, attach print out of current medications):

Date Primary Care Provider discussed referral with Patient:

Reason for Referral to Mental Health:

- ☐ Depression symptoms but not suicidal, homicidal, or gravely disabled
("Gravely Disabled"-unable to provide for his or her basic needs for food, clothing or shelter due to a mental disorder)
- ☐ Anxiety symptoms
- ☐ Social stressors
- ☐ Mood symptoms related to medical diagnosis
- ☐ Other (please explain below)

Care Coordinator Information

Care Coordinator Name & Title:

Phone Number:

Fax Number:

Referring Provider Information

Print Name & Title of Referring Provider:

Signature:

Date:

Time:

Name of Clinic:

Contact Number:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

IS#:

Agency:

Provider #:

Los Angeles County - Department of Mental Health

DMH REFERRAL from HEALTHCARE PROVIDERS

DEPARTMENT OF MENTAL HEALTH REFERRAL FORM from HEALTHCARE PROVIDERS

Purpose: This form is for the use of Primary Care Providers (PCP) when making referrals of non-emergency clients to the Department of Mental Health.

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

INFORMATION ONLY

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names

Birth Date

MIS Number

Street Address

City, State, Zip

AUTHORIZES:

**DISCLOSURE OF PROTECTED HEALTH
INFORMATION TO:**

Name of Agency

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Results of Psychological Tests ☐ Diagnosis
☐ Laboratory Results ☐ Medication History/ ☐ Treatment
☐ Entire Record (Justify) ☐ Current Medications
☐ Other (Specify): _____

PURPOSE OF DISCLOSURE: (Check applicable categories)

☐ Client's Request
☐ Other (Specify): _____

Will the agency receive any benefits for the disclosure of this information? ☐ Yes ☐ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

INFORMATION ONLY

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

Contact person

Agency Name

Street Address

City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: ____ / ____ / ____
Month Day Year



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

FINAL LETTER OF RESPONSE TO CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS TO HEALTH INFORMATION

{Mr./Ms./Mrs. Client's Name}

{Client's Address}

{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

We have completed a separate, independent review of your initial Request for Access to Health Information in response to your Request for Review of Denial for Access. We have determined that:

☐ Your request has been accepted, and the information is included with this notice. The cost for this service is \$ _____, based on a charge of 25 cents per page, and a bill will be sent to your home of record.

☐ Your request has been accepted, and the following appointment time has been scheduled for your records review:

Date: {Date}

Time: {Time}

Location: {Facility Address}

If you have any questions or need to reschedule, please contact the Treatment Team or call us at
{Facility Phone No.}

☐ We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

☐ You are not authorized access to the health information.



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

Other:

FINAL DENIAL (IF APPLICABLE)

If your request has been denied, either partially or in whole, after submitting a Request for Review of Denial for Access, we would like to remind you that you, as stated in the Notice of Privacy Practices, that you have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,
US Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Department of Mental Health
Los Angeles County

CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

I am requesting a review of denial of access to my protected health information.

LACDMH will designate a licensed health care professional, who was not involved in the decision to deny access, to review the determination. We will notify you in writing of the determination of the reviewing health care professional. LACDMH must adhere to the determination of the reviewing professional.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

Facility

Practitioner

Date

For more information about your health privacy rights, ask the Treatment Team for a copy of our Notice of Privacy Practices. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

**Patient's Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**LETTER RESPONDING TO CLIENT'S REQUEST
FOR ACCESS TO HEALTH INFORMATION**

{Mr./Ms./Mrs. Client's Name}

{Client's Address}

{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your **Request for Access to Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your written request, stamped on mm/dd/yyyy, to access your protected health information. We have determined that:

- ☐ Your request has been accepted, and the information is included with this notice. The cost for this service is \$ _____, based on a charge of 25 cents per page, and a bill will be sent to you home of record.
- ☐ Your request has been accepted, and the following appointment time has been scheduled to for your records review:
- Date: {Date}
 Time: {Time}
 Location: {Facility Address}
- If you have any questions or need to reschedule, please contact the Treatment Team or call us at*
 {Facility Phone No.}

- ☐ We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

- ☐ You are not authorized access to the health information.
- ☐ We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. This denial is not subject to the right to review.
- ☐ You did not provide all the information we need to complete your request. Please complete the highlighted items identified and return it to us.
- ☐ You were unable to provide satisfactory personal identification to access your own information.
- ☐ You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- ☐ Other:

If we denied your request to access, you have the right to require LACDMH to permit inspection by, or provide copies to, a licensed mental health professional designated by you with your written authorization. If you want to exercise this right, please contact your Treatment Team.

Request for Review of Denial of Access (IF APPLICABLE)

If we denied your request to access your protected health information, in whole or in part, you may submit a *Request for Review of Denial of Access*, included with this letter. After completing the form, return it to the Treatment Team or mail it to:

Los Angeles County Department of Mental Health (LACDMH)
Patient's Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

You also have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPPO@cio.co.la.ca.us**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}

Program / Unit Manager

Department of Mental Health

Los Angeles County

CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client

Birth Date of Client

MIS #

Street Address

City, State, Zip

- ☐ **REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE**
- ☐ **REQUEST DMH SEND A COPY OF MY REQUESTED HEALTH INFORMATION TO:**

Name

FAX Number (include area code)

Street Address

City, State, Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information regarding the following time period:

FROM ____/____/____ **TO** ____/____/____
Month Day Year Month Day Year

- ☐ **REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

COPY FEES: DMH MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY; 50 CENTS PER PAGE FOR MICROFILM.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I must be provided with a signed copy of the form.

Right to Request Review of Denial of Access- I understand that DMH may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a *Request for Review of Denial of Access*. In most circumstances, DMH will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

SIGNATURE OF CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE:

If signed by other than client, state relationship and authority to do so:

DATE: ____/____/____
Month Day Year

FORM(S) OF IDENTIFICATION PROVIDED:

___ State Driver's License _____
___ State Identification Card _____
___ Birth Certificate _____
___ Military ID _____
___ Other (Provide details) _____

FACILITY: _____

PRACTITIONER: _____

DATE: ____/____/____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our Notice of Privacy Practices. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

Patient's Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**LETTER RESPONDING TO REQUEST TO
AMEND/CORRECT HEALTH INFORMATION**

{Mr./Ms./Mrs. Client's Name}

{Client's Address}

{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting to us your **Request to Amend/Correct Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your request to amend/correct your protected health information dated. {Insert Date}

We have determined that:

- ☐ We will make the change as you requested and will notify the persons you designated of the change.
- ☐ We need more time to process your request. We will send you a response to your request by {Insert Date}

REASON FOR PARTIAL DENIAL (IF APPLICABLE)

- ☐ We will make the change that you requested, but only in part, and will notify the persons you designated of the change.

- ☐ The part of the change that we will make is:

- ☐ The part of the change that we will not make is (include reason):



INFORMATION ONLY

Los Angeles, CA 90020

REASON FOR FULL DENIAL (IF APPLICABLE)

Your request to change your protected health information is denied because:

- ☐ You did not include a reason to support your request.
- ☐ The information we have is deemed accurate and complete.
- ☐ We did not create the information you want changed, and you did not give us a reasonable basis to believe that the originator of the information is no longer available to act on your request to change the information.
- ☐ The information you want changed is not information that you have a right to access.
- ☐ The information you want changed is not part of the designated record set. This means your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.
- ☐ Other:

YOUR RIGHTS IF WE DENIED YOUR REQUEST TO AMEND (IF APPLICABLE)

If we denied your request to change your protected health information, in whole or in part, you may submit a **Statement of Disagreement**. If you do not want to submit a Statement of Disagreement, you may ask us to include your amendment (change) request and our denial along with all future disclosures of the information that you wanted changed by completing the appropriate section on the **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures** form.

If you want to submit a **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures**, please request the form from the Treatment Team. After completing the form, return it to the Treatment Team or mail it to:

Los Angeles County Department of Health Services (LACDHS)
Patient's Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020

You have the right to submit a complaint to the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street
Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,
US Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

(Name)
Department of Mental Health
Los Angeles County

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

REQUEST DMH SEND THE RESPONSE TO THIS REQUEST TO:

Name

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND/ CORRECT:

PLEASE TELL US WHY YOU THINK THE AMENDMENT OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

If we decide to amend/correct the health information as you requested, we will send the amendment/correction to the persons or organizations you identified below. Please identify any other persons or organizations you believe have received your health information and need to be notified of the amendment/correction that you are requesting:

1st Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

2nd Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

INFORMATION ABOUT YOUR AMENDMENT/CORRECTION RIGHTS

DMH will not process your request for an amendment/correction of your health information if it is not made in writing on this Form or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.

If DMH denies your requested amendment, we will tell you in writing how to submit a *Statement of Disagreement*, or a complaint, or how to request that we include your amendment request in your health information that we maintain.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

FORM(S) OF IDENTIFICATION PROVIDED:

____ State Driver's License _____
____ State Identification Card _____
____ Birth Certificate _____
____ Military ID _____
____ Other (Provide details) _____

Facility

Practitioner

Date

For more information about your health privacy rights, ask the Treatment Team for a copy of our Notice of Privacy Practices. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

**Patient's Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**LETTER RESPONDING TO CLIENT'S REQUEST
FOR ACCOUNTING OF DISCLOSURES**

{Mr./Ms./Mrs. Client's Name}

{Client's Address}

{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your Request for Accounting of Disclosures. We received your written request, stamped on _____ for an accounting of disclosures of your protected health information. We have determined that:

- ☐ We need additional time to process your request. We will send you an accounting of disclosures by _____.
- ☐ We have attached a copy of your Request for an Accounting of Disclosures Form with the areas marked that need further information for your request to be processed. Please complete the enclosed Form and return it to us for reconsideration.
- ☐ You have already received one free accounting of disclosures within the last 12 months. An additional accounting will cost \$ _____. Please send a check for this amount, made payable to {Insert Name of Facility}, or bring it to the {Insert Name of Facility} at {Insert Facility Address}.

Please include this Response to Request for Accounting of Disclosures Form with your check.

☐ Other:



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}

Program / Unit Manager
Department of Mental Health
Los Angeles County

REQUEST FOR ACCOUNTING OF DISCLOSURES

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

I understand that the first accounting in a twelve (12) months period is free of charge, but that I can be charged a reasonable fee for any additional accountings.

I understand that that the accounting must include all disclosures, **except** for disclosures:

1. to carry out treatment, payment and health care operations;
2. to individuals of protected health information about them;
3. incident to a use or disclosure permitted by the Privacy Regulations;
4. pursuant to the individual's authorization;
5. to persons involved in the individual's care or for a facility directory;
6. for national security or intelligence purposes;
7. to correctional institutions or law enforcement officials to provide them with information about a person in their custody;
8. as part of a limited data set; or
9. that occurred prior to the compliance date.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____



INFORMATION ONLY

DEPARTMENT OF MENTAL HEALTH

DMH FAX COVER FOR TRANSMITTING PHI

FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: _____

TO

FROM

Name: _____

Name: _____

Facility: _____

Facility: _____

Address: _____

Address: _____

Telephone #: _____

Telephone #: _____

Fax #: _____

Fax #: _____

Documents being faxed:

☐ Clinical Records

☐ Other: _____

CONFIDENTIALITY STATEMENT

This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received the transmission in error, please notify contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

DMH Treatment Team Representative



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

**REPRESENTATION OF RESEARCHER TO REVIEW
PROTECTED HEALTH INFORMATION HELD BY LOS ANGELES
COUNTY DEPARTMENT OF MENTAL HEALTH TO PREPARE FOR RESEARCH**

Name of requesting individual:	Date:
--------------------------------	-------

Describe the health information that is the subject of the request to review:

--

Explain the purpose supporting the need to access the health information:

--

By signing this form, I hereby represent to the Human Subjects Research Committee (HSRC) and to the Department of Mental Health the following:

- a. My review of the health information will be limited as necessary for me to prepare for research.
- b. I will not remove the health information from the area allocated to me by the Department to review the health information, and will record the health information reviewed only in a manner that the subjects of the information cannot be identified.
- c. My review of the health information is necessary for the research I am conducting.

_____ Researcher's Name (Print)	_____ Signature	_____ Date
_____ Signature of HSRC Committee Member		_____ Date



DEPARTMENT OF MENTAL HEALTH

INFORMATION ONLY

REPRESENTATION OF RESEARCHER TO REVIEW PROTECTED HEALTH INFORMATION OF DECEDENTS HELD BY LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Name of requesting individual:	Date:
--------------------------------	-------

Describe the health information that is the subject of the request to review:

--

Explain the purpose supporting the need to access the health information:

--

By signing this form, I hereby represent to the Human Subjects Research Committee (HSRC) and to the Department of Mental Health the following:

- I am reviewing the health information only for the limited purpose of research using decedents' health information.
- My review of the health information is necessary for the research I am conducting.
- If the Department so requests, I will provide documentation of death of the individuals whose health information I will review.

_____ Researcher's Name (Print)	_____ Signature	_____ Date
_____ Signature of HSRC Committee Member		_____ Date

SECTION III

☐ Admission Diagnosis ☐ Clerical Revision to Admission Diagnosis ☐ Clerical Revision to Current Diagnosis
☐ Clinical Update to Current Diagnosis ☐ Other (please specify): _____

Note: The medication monitoring computer program will compare both the Principle and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication **MUST** appear as either the Principle or Secondary Diagnosis in the current/discharge diagnosis fields of the IS. If a diagnosis is inconsistent for the usual use of a medication, the medication **MUST** be specifically authorized through review and approval procedures.

<input type="checkbox"/> Sec	Code _____	Nomenclature _____
	Code _____	Nomenclature _____
	Code _____	Nomenclature _____
	Code _____	Nomenclature _____

Axis II

<input type="checkbox"/> Prin	<input type="checkbox"/> Sec	Code _____	Nomenclature _____
	<input type="checkbox"/> Sec	Code _____	Nomenclature _____
		Code _____	Nomenclature _____

Axis III _____ **Code** _____
 _____ **Code** _____
 _____ **Code** _____

1. ☐ Primary Support Group 2. ☐ Social Environment 3. ☐ Educational 4. ☐ Occupational
5. ☐ Housing 6. ☐ Economics 7. ☐ Access to Health Care 8. ☐ Interaction with Legal System
9. ☐ Other Psychosocial/Environmental 10. ☐ Inadequate information

Axis V Current GAF: _____ DMH Dual Diagnosis Code: _____

☐ See Initial Medication Support Service dated _____ ☐ See Assessment Addendum dated _____

☐ Justification from current Diagnostic Manual:

Date _____

☐ Diagnosis has been entered in the IS by _____ (initials) on _____ (date).

Los Angeles County – Department of Mental Health

DIAGNOSIS INFORMATION

SPECIAL PROGRAM CCCP

Annual Cycle Month: (Due prior to the 1st day of the Month)

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1

Effective Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other _____

Client Involvement - Client agrees to participate by:

Signature(s)

Print Name

Signature & Discipline

Date

Co-signature & Discipline

Date

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month.

Initials:

Date:

Short-term Goals / Objectives:

Objective # 2

Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other _____

Client Involvement - Client agrees to participate by:

Signature(s)

Print Name

Signature & Discipline

Date

Co-signature & Discipline

Date

Outcomes:

Initials:

Date:

*MHS includes individual, group, psychological testing, collateral and consultation services.

Family Involvement: ☐ Biological ☐ Other

Name: _____ Telephone Number: _____ Date of contact: _____

Family agrees to participate? ☐ Yes ☐ No (If yes, please specify):

Additional Client Contacts / Relationships:

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds
☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run
☐ Education/AB 3632 ☐ Other _____

Interpretation

Prefer a language other than English:
☐ Yes ☐ No
This plan was interpreted: ☐ Yes ☐ No
Language: _____

Client's Signature to the Care Plan

Client's Signature: _____
Date: _____
Client offered a copy: ☐ Yes ☐ No
Staff Initials: _____ Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name:

IS#:

Agency:

Provider #:

Los Angeles County - Department of Mental Health

Special Program Client Care Coordination Plan

ADULT SHORT ASSESSMENT

Interviewed: ☐ Client and/or ☐ Other (name and relationship): _____

Special Service Needs:

☐ Non-English Speaking, specify language needs: _____

Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

I. Reason for Referral/Chief Complaint ☐ See Information on _____ dated: _____

Reason for Referral

Current Symptoms/Behaviors

Impairments in Life Functioning (daily living activities, social, employment/education, housing, financial, etc)

II. Psychiatric History ☐ See Information on _____ dated: _____

Outpatient and Inpatient, include dates, providers, interventions, and responses ☐ See information on IS Screen Prints

III. Current Risk and Safety Concern ☐ See Information on _____ dated: _____

Current Thoughts of Self-Harm/Suicide

☐ Yes ☐ No

Past Thoughts of Self-Harm/Suicide

☐ Yes ☐ No

Prior Suicide Attempts/If yes, # _____

☐ Yes ☐ No

Probation/Parole Involvement

☐ Yes ☐ No

Current/History of Injuring Animals

☐ Yes ☐ No

Recent Trauma Exposure

☐ Yes ☐ No

Recent Job Loss

☐ Yes ☐ No

Victim of Violence/Abuse

☐ Yes ☐ No

DCFS Involvement

☐ Yes ☐ No

Other (specify): _____

Current Thoughts of Harming Another Person

☐ Yes ☐ No

Past Thoughts of Harming Another Person

☐ Yes ☐ No

History of Homicide/Manslaughter

☐ Yes ☐ No

History of Injuring Another Person

☐ Yes ☐ No

School Issues or IEP in place

☐ Yes ☐ No

Current Substance Use/Abuse

☐ Yes ☐ No

Past Substance Use/Abuse

☐ Yes ☐ No

Perpetrator of Violence/Abuse

☐ Yes ☐ No

Homeless

☐ Yes ☐ No

For any risk/safety concerns marked yes, please explain. Identify if any safety measures are needed, required or taken.

IV. Relevant Medical Conditions ☐ See Information on _____ dated: _____

Hearing Impairment

☐ Yes ☐ No

Visual Impairment

☐ Yes ☐ No

Motor Impairment

☐ Yes ☐ No

Other Sensory Impairment

☐ Yes ☐ No If yes, specify: _____

Allergies

☐ Yes ☐ No If yes, specify: _____

Other Medical Conditions

☐ Yes ☐ No If yes, specify: _____

Last Physical Exam Date: _____

Other Comments Regarding Medical Conditions: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County – Department of Mental Health

ADULT SHORT ASSESSMENT

V. Medications

Client is currently on medications: ☐ Yes ☐ No If yes, How many days of medication does the client have left? _____
If yes, specify medications (include name and if there are any side-effects/adverse reactions).

VI. Substance Use/Abuse

"MH659 -Co-Occurring Joint Action Council Screening Instrument"

1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? ☐ Yes* ☐ No If yes, complete A and B below

2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? ☐ Yes ☐ No If yes, answer 2a

2a. Was the Trauma or Domestic Violence related to substance use? ☐ Yes* ☐ No If yes, complete A and B below

1 Drink = 12 Ounces of Beer

A. Alcohol Screening Questions

1. How often do you have a drink containing alcohol?
If "Never", proceed to Drug Screening Questions.

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 3 times a week ☐ 4+ times a week

1a. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10+

1b. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

2. Drug Type(s) Used
(Indicate with an "*" which substances are most preferred.)

Ever Used? Recently Used?
(Past 6 Months)

Route of Administration or other comments
(IV use, smoking, snorting, etc.)

	Yes	No	Yes	No
Amphetamines (Meth, crank, ice, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (Cigarettes, cigars, smokeless tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates (Heroin, codeine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the Counter Meds (Cough syrup, diet aids, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives (Pain meds, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Additional Comments (i.e. frequency, duration of use, etc.):

VII. Psychosocial ☐ See Information on

dated: _____

Family & Relationships, Dependent Care Issues (Number of Dependents, Ages, Needs & Special Needs), Current Living Arrangement, Social Support Systems, Education, Employment History/Readiness/Means of Financial Support, Legal History and Current Legal Status which may impact linkage/referral.

VIII. Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run/NAMI ☐ Education/AB 3632
☐ Other _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#: _____

Agency: _____

Provider #: _____

Los Angeles County - Department of Mental Health

IX. Mental Status

General Description

Grooming & Hygiene: ☐ Well Groomed
☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled
☐ Bizarre

Eye Contact: ☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic

Motor Activity: ☐ Calm ☐ Restless
☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid
☐ Retarded ☐ Akathesis ☐ E.P.S.

Speech: ☐ Unimpaired ☐ Soft ☐ Slowed
☐ Mute ☐ Pressured ☐ Loud ☐ Excessive
☐ Slurred ☐ Incoherent ☐ Poverty of Content

Interactional Style: ☐ Culturally congruent
☐ Cooperative ☐ Sensitive
☐ Guarded/Suspicious ☐ Overly Dramatic
☐ Negative ☐ Silly

Orientation: ☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation

Intellectual Functioning: ☐ Unimpaired
☐ Impaired

Memory: ☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent
☐ Amnesia

Fund of Knowledge: ☐ Average
☐ Below Average ☐ Above Average

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Irritable ☐ Lack of Pleasure
☐ Hopeless/Worthless ☐ Anxious
☐ Known Stressor ☐ Unknown Stressor

Affect: ☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad ☐ Worried

Perceptual Disturbance

☐ None Apparent
Hallucinations: ☐ Visual ☐ Olfactory
☐ Tactile ☐ Auditory: ☐ Command
☐ Persecutory ☐ Other
Self-Perceptions: ☐ Depersonalizations
☐ Ideas of Reference

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose

☐ Tangential ☐ Circumstantial

☐ Confabulous

☐ Flight of Ideas ☐ Word Salad

Concentration: ☐ Intact ☐ Impaired by:

☐ Rumination ☐ Thought Blocking

☐ Clouding of Consciousness

☐ Fragmented

Abstractions: ☐ Intact ☐ Concrete

Judgments: ☐ Intact

☐ Impaired re: ☐ Minimum ☐ Moderate

☐ Severe

Insight: ☐ Adequate

☐ Impaired re: ☐ Minimum ☐ Moderate

☐ Severe

Serial 7's: ☐ Intact ☐ Poor

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid

☐ Grandiose ☐ Somatic ☐ Religious

☐ Nihilistic ☐ Being Controlled

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious

☐ Obsessive ☐ Blames Others ☐ Persecutory

☐ Assaultive Ideas ☐ Magical Thinking

☐ Irrational/Excessive Worry

☐ Sexual Preoccupation

☐ Excessive/Inappropriate Religiosity

☐ Excessive/Inappropriate Guilt

Behavioral Disturbances: ☐ None

☐ Aggressive

☐ Uncooperative ☐ Demanding ☐ Demeaning

☐ Belligerent ☐ Violent ☐ Destructive

☐ Self-Destructive ☐ Poor Impulse Control

☐ Excessive/Inappropriate Display of Anger

☐ Manipulative ☐ Antisocial

Suicidal/Homicidal: ☐ Denies ☐ Ideation Only

☐ Threatening ☐ Plan ☐ Past Attempts

Passive: ☐ Amotivational ☐ Apathetic

☐ Isolated ☐ Withdrawn ☐ Evasive

☐ Dependent

Other: ☐ Disorganized ☐ Bizarre

☐ Obsessive/compulsive ☐ Ritualistic

☐ Excessive/Inappropriate Crying

Comments on Mental Status:

X. Summary

Summary/ Clinical Impression (including strengths and attitude towards treatment):

Diagnosis: Axis I ☐ Prim ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
 Axis II ☐ Prim ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
 Axis III _____ Code _____ Nomenclature _____
 _____ Code _____ Nomenclature _____
 _____ Code _____ Nomenclature _____
 Axis IV 1. ☐ Primary support group 2. ☐ Social environment 3. ☐ Educational 4. ☐ Occupational
 5. ☐ Housing 6. ☐ Economics 7. ☐ Access to health care 8. ☐ Interaction w/legal system
 9. ☐ Other psychosocial/environmental 10. ☐ Inadequate information
 Axis V GAF _____ Dual Diagnosis Code: _____

Disposition/Recommendations/Plan:

Signature & Discipline

Date _____

Co-Signature & Discipline (if required)

Date _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____

IS#:

Agency:**Provider #:**

Los Angeles County – Department of Mental Health

**ADULT
ASSESSMENT ADDENDUM**

Please categorize information into one of the following areas when updating the initial assessment:

Demographic Data
Presenting Problem/Chief Complaint
Psychiatric History

Medical History
Medications
Substance Use/Abuse

Psychosocial History
Mental Status Evaluation
Summary and Diagnosis

DATE	NOTES

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Name:

MIS #:

Agency:

Prov. #:

Los Angeles County - Department of Mental Health

ADULT ASSESSMENT ADDENDUM

**APPLICATION FOR 72 HOUR DETENTION
FOR EVALUATION AND TREATMENT**

MH 302 (Rev. 08/04) Front

Confidential Client/Patient InformationSee California WIC Section 5328 and
HIPAA Privacy Rule 45 C.F.R. § 164.508

Welfare and Institutions Code (WIC), Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

☐ **Advisement Complete**☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By

DETAINMENT ADVISEMENT

My name is _____

I am a (Peace Officer, etc.) with (Name of Agency).
You are not under criminal arrest, but I am taking you
for examination by mental health professionals at
(Name of Facility).

You will be told your rights by the mental health staff.

*If taken into custody at his or her residence, the
person shall also be told the following information in
substantially the following form:*

You may bring a few personal items with you which I
will have to approve. You can make a phone call
and/or leave a note to tell your friends and/or family
where you have been taken.

Position

Date

To _____

Application is hereby made for the admission of _____

Residing at _____, California, for 72-
hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the WIC. If a
minor, to the best of my knowledge, the legally responsible party appears to be / is: (Circle one) Parent; Legal Guardian;
Juvenile Court as a WIC 300; Juvenile Court as a WIC 601/602; Conservator. If known, provide names, address and
telephone number:

The above person's condition was called to my attention under the following circumstances: (see reverse side for definitions)

The following information has been established: (Please give sufficiently detailed information to support the belief that the person
for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself; herself and/or gravely disabled.)

Based up on the above information it appears that there is probable cause to believe that said person is, as a result of mental
disorder:

☐ A danger to himself/herself. ☐ A danger to others. ☐ Gravely disabled adult. ☐ Gravely disabled minor.

Signature, title and badge number of peace officer, member of attending staff of evaluation facility or person
designated by county.

Date

Phone

Time

Name of Law Enforcement Agency or Evaluation Facility/Person

Address of Law Enforcement Agency or Evaluation Facility/Person

☐ Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to Section 8102 WIC.

(officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

**NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE
OFFICER BECAUSE:**

☐ Person has been referred under circumstances in which criminal charges might be filed pursuant to Sections 5152.1 and 5152.2 WIC.

Notify (officer/unit & telephone #) _____

☐ Weapon was confiscated pursuant to Section 8102 WIC.

Notify (officer/unit & telephone #) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

**APPLICATION FOR 72 HOUR DETENTION
FOR EVALUATION AND TREATMENT**

MH 302 (Rev. 08/04) Back

DEFINITIONS**GRAVELY DISABLED**

"Gravely Disabled" means a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing and shelter. SECTION 5008(h) WIC

"Gravely Disabled Minor" means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Mental retardation, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. SECTION 5585.25 WIC

PEACE OFFICER

"Peace Officer" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or any parole officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility. SECTION 5008(i) WIC

INSTRUCTIONS FOR SECTION 5152.1, 5152.2 AND 5585 WIC**Section 5152.1 WIC**

The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the conditions apply:

- (a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.
- (b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release. If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer agency, or designee shall destroy that record two years after receipt of notification.

Section 5152.2 WIC

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officer pursuant to Section 5152.1 WIC.

Section 5585 et seq. WIC

Section 300 WIC is a minor who is under the jurisdiction of the Juvenile Court because of abuse (physical or sexual), neglect or exploitation.

Section 601 WIC is a minor who is adjudged a ward of the Juvenile Court because of being out of parental control.

Section 602 WIC is a minor who is adjudged a ward of the Juvenile Court because of crimes committed.

Section 8102 WIC (EXCERPTS FROM)

- (a) Whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in Section 8100 or 8103, is found to own, have in his or her possession or under his or her control, any firearm whatsoever, or any other deadly weapon, the firearm or other deadly weapon shall be confiscated by any law enforcement agency or peace officer, who shall retain custody of the firearm or other deadly weapon.

"Deadly weapon," as used in this section, has the meaning described by Section 8100.

- (b) Upon confiscation of any firearm or other deadly weapon from a person who has been detained or apprehended for examination of his or her mental condition, the peace officer or law enforcement agency shall notify the person of the procedure for the return of any firearm or other deadly weapon which has been confiscated.

Where the person is released without judicial commitment, the professional person in charge of the facility, or his or her designee, shall notify the person of the procedure for the return of any firearm or other deadly weapon which may have been confiscated.

Health facility personnel shall notify the confiscating law enforcement agency upon release of the detained person, and shall make a notation to the effect that the facility provided the required notice to the person regarding the procedure to obtain return of any confiscated firearm.

SECTION IV

DISCHARGE SUMMARY

Admission Date: _____

Discharge Date*: _____

Presenting Information:

Services Received and Response:

Medication(s): (Include Dosage & Response) ☐ None

Disposition and Recommendations: (If referred, include name of agency(s) or practitioner(s))

Referral Out Code _____

Diagnosis: (check one)

Axis I ☐ Prin / Sec _____ Code _____

☐ Prin / Sec _____ Code _____

Axis II ☐ Prin / Sec _____ Code _____

Axis III ☐ _____ Code _____

Axis V ☐ Discharge GAF _____ Prognosis _____

Signature & Discipline

Date

Reviewer's Signature & Discipline

Date

*Discharge Date: last service date or last cancelled or missed appointment.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Name: _____

MIS #: _____

Agency: _____

Prov. #: _____

Los Angeles County - Department of Mental Health

DISCHARGE SUMMARY

PROGRESS NOTE

Date: _____ Telephone Contact: ☐ Y ☐ N Rendering Provider Face-to-Face/Other Time* (Hrs:Mins): _____
Procedure Code: _____ Other Staff Initials: _____ Total Time* (Hrs:Mins): _____
* All travel and documentation time must be recorded as "Other" or "Total Time" Other Staff Initials: _____ Total Time* (Hrs:Mins): _____
MHS Activity Type: ☐ Assessment ☐ Ind Tx ☐ Ind Reh ☐ Col ☐ PsyT ☐ Team Conf/CaseCon Other Activity Type: ☐ Cris Int
☐ GrpTx ☐ GrpReh # of Clients Represented: _____ ☐ TCM

☐ Continued (Sign & complete claim information on last page of note.)

Signature & Discipline

Date

Co-signature & Discipline

Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name:

IS#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

PROGRESS NOTE

CASE PRESENTATION

Purpose: This form provides a unique place for the documentation of any one of a variety of formal staff conference activities: Interdisciplinary case conferences, periodic case reviews, problem case conferences, case training conferences, disposition, conferences, transfer conferences, intake conferences, etc. In essence, it is the form that should be used to document any case conference activities that occur in a provider.

Verbal Content of Presentation: These sample items are not intended to set minimum standards or requirements for a presentation. It is intended primarily to assist students and new professionals in preparing a presentation. Many conferences will have a focus that does not include all of the elements listed, such as a conference focused on a discharge plan. Other conferences may specifically include areas not noted, but relevant to the type of conference or presentation.

Recording Procedure: The Documentation section is intentionally brief. It was designed to highlight only the issues discussed and service suggestions made at the presentation. There are a variety of other places in the service record where summaries of the patient, his/her service, or any other aspects of the case may be found. In the face of ever increasing demands on service time, it seemed unnecessary to repeat this information, thus the focus on the discussion aspect of the case conference and information which may not be available elsewhere in the service record. Individual programs may require additional documentation by specifying required content in service procedures.

If additional space is needed, use a *Progress Notes* page. Cross out any unused space at the end of the case presentation documentation.

Reason for Presentation: This should be a brief statement (such as problem specific, periodic review, interdisciplinary case conference, disposition, etc.). If the presentation is problem specific, a brief statement of the problem should follow.

Signature: The service staff presenting the case should complete and sign the form. Supervisors are encouraged to review conference documentation of their supervisees. All student/trainee notes must be co-signed by his/her licensed supervisor.

Filing Procedure: This form should be filed sequentially in the progress notes section of the service record.

**CHIEF INFORMATION
OFFICE BUREAU
(CIOB)**

DATA ENTRY

What is the IS?

- The Integrated System (IS) is the Department's proprietary health care claims processing system.
- IS has integrated some clinical data requirements.
- The IS will be replaced with a more robust off-the-shelf electronic health record system in the near future.

How do Contract Providers Access the IS?

- Access is through the Internet
- Use RSA security technology
- IS Website
 - ✓ <http://dmh.lacounty.gov/hipaa/index.html>

How Much Training Is Required?

- DMH offers a 1-day training session that goes over basic IS operations.
- For more information please visit the IS website.
 - ✓ <http://dmh.lacounty.gov/hipaa/index.html>

IS Training Dates

- | | |
|-----------------|-----------------------|
| ➤ July 6, 2011 | 9:00 a.m. – 3:30 p.m. |
| ➤ July 12, 2011 | 9:00 a.m. – 3:30 p.m. |
| ➤ July 14, 2011 | 9:00 a.m. – 3:30 p.m. |
| ➤ July 28, 2011 | 9:00 a.m. – 3:30 p.m. |

Entering Data in the IS

- Enrollment
 - ✓ Identification
 - ✓ Contact Information
- Episode
 - ✓ Admit date
 - ✓ Discharge date
- Financials
 - ✓ UMDAP

Access Forms

- CIOB/Information Security Division
 - Systems Access Unit

Facilitating Form Processing

Individual Authorized To Sign CIOB Forms

➤ To meet departmental guidelines and other internal controls we require that all forms carry the signature of Program Director level or above.

- Responsible person i.e. CEO, Program Director, Deputy, etc. May also designate additional individuals to sign required forms to authorized access to the Integrated System (Data Entry) or permit service delivery staff (rendering provider) association to Legal Entity reporting unit (s).
- Form Link:
<http://dmh.lacounty.gov/hipaa/documents/Auth%20Sign%20CIOB%20Revised.pdf>

Individual Authorized to Sign CIOB Forms

- This SAMPLE Form indicates required fields.
- CEO may designate a Designee and an Alternate.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CIO BUREAU/SYSTEMS AND OPERATION/HELP DESK

INDIVIDUALS AUTHORIZED TO SIGN CIOB FORMS

☒ New ☐ Replace Signatures on File ☐ Add to Signatures on File

Legal Entity # 9999 Check Box for Type

Reporting Unit (s): 9999A, 9999R, 9999S, 9999W ☐ DMH ☒ NGA ☐ FFS ☐ DHS

Provider/Agency Name: BELOVED MEDICAL CENTER

Address: 1234 NEWWAVE BLVD HAPPY CITY CA 01234
Street City State Zip

Telephone Number: (201) 561-2015 213
Area Code Number Extension

Director Level or Above: DR. SALLY BEGONE MD, CEO

Print/Type
 Director's Level or Above Signature: Dr. Sally Begone MD

Director's E-Mail Address: sally.begone@medctr.com

The following individuals are authorized to sign CIOB Forms submitted by the above name agency:

Name of Designee: Town Little Print/Type

Signature of Designee: Town Little

Title: Office Manager

E-Mail Address: Town.Little@medctr.com Phone: (201) 561-2018

Name of Alternate: Help Me Print/Type

Signature of Alternate: Help Me

Title: Billing Manager

E-Mail Address: help.me@medctr.com Phone: (201) 561-2055

Date Submitted to CIOB: May 3, 2010

NOTICE: FAX WILL NOT be accepted. Original signatures are required.
 Return completed form to: LA County, Department of Mental Health
 CIO Bureau/IS-Systems Access
 695 S. Vermont Avenue
 Los Angeles, CA 90005

Authorized signers.doc/julipg85
 Revised: 01/21/2010

**S
A
M
P
L
E**

Integrated System Access

Direct Data Entry and/or Support Staff

Forms Required

➤ **Applications Access (AAF)**

- allows creation of end-user profile in the IS
- role assignments allow client searches, maintain data, medication, reports, etc.
- provider number association restricts access to client's information by provider number association.

➤ **RSA SecurID Card**

- **Downey Data Center Registration, Contractor (DDCR)**
 - Provides a securID card. Initial authentication to permit end-users through the County's Firewall.
- **Agreement For Acceptable Use and Confidentiality of...(AUP)**
 - User acknowledgement of confidentiality and violation penalties.

➤ **Submit 3 forms (AAF, DDCR, and AUP) to CIOB/Information Security Division/Systems Access, 695 S. Vermont Ave, 8th Fl, LA 90005**

- Processing time 2 to 3 weeks
 - Mail to Provider or Provider may pick-up Logon Packet

➤ **Confidentiality Oath**

- Maintained by Provider

➤ ***To terminated services from a provider location submit an AAF, DDCR and the RSA SecurID Card.***

“IS Forms” link

http://dmh.lacounty.info/hipaa/cp_ISForms.htm

The screenshot shows a web browser window displaying the "Integrated System" website. The browser's address bar shows the URL http://dmh.lacounty.gov/hipaa/cp_ISForms.htm. The website has a header with the text "Integrated System" and "To Enrich Lives Through Effective and Caring Service". Below the header is a navigation bar with links: "IS HOME", "DIRECTLY OPERATED CLINICS", "OUTPATIENT FEE-FOR-SERVICE", and "CONTRACT PROVIDERS". The main content area is divided into two columns. The left column, titled "Working in the IS", contains a list of links: "Special Bulletins!", "Getting Started on the IS", "Getting IS Training", "Using the IS", "Using IS Reports", "Handling Error Msgs. & Denials", "IS Forms", "Clinical Forms", "Co-Occurring Disorders Forms", "Getting Help with the IS", "Links", and "EDI / Secure File Transfer". The right column, titled "IS Forms", contains the text "These forms are for Contract Providers ~ Face Sheets/Billing Forms ~" and a list of links: "Procedures for Forms", "Integrated System Access", "Applications Access Form Instructions rev. 6/06", "Applications Access Form rev. 6/06 SAMPLE", "Applications Access Form Attachment", "Applications Access Form Codes", "Integrated System Access Roles rev. 01/10/07", "Authorization to Sign CIOB Access Forms rev. 1/10 SAMPLE", "DMH Policy 302.18 on 'Security and Integrity of the Department's IS' Confidentiality Oath ~ SAMPLE", "Downey Data Center Registration/Non-County rev. 03/10 SAMPLE", "IS Connection Options", "SecurID Renewal Non County and AUP and Sample Form and Sample AUP", "Request for Replacement of Lost PIN", "Request to Change Funding Source on COS", "Service Delivery Staff", and "Rendering Provider Form PDF rev. 3/14". A red arrow points from a green callout box to the "Applications Access Form rev. 6/06 SAMPLE" link. The callout box contains the text "Link to Data Entry Staff Forms: http://dmh.lacounty.gov/hipaa/cp_ISForms.htm" and "Required forms, instructions, codes, roles and other helpful information are listed under Integrated System Access." A blue circle with the word "Sample" in red is also present in the bottom right corner of the screenshot.

Integrated System
To Enrich Lives Through Effective and Caring Service

IS HOME DIRECTLY OPERATED CLINICS OUTPATIENT FEE-FOR-SERVICE CONTRACT PROVIDERS

Working in the IS ← → IS Forms

Special Bulletins!

Getting Started on the IS

Getting IS Training

Using the IS

Using IS Reports

Handling Error Msgs. & Denials

IS Forms

Clinical Forms

Co-Occurring Disorders Forms

Getting Help with the IS

Links

EDI / Secure File Transfer

These forms are for Contract Providers
~ Face Sheets/Billing Forms ~

Procedures for Forms

- **Integrated System Access**
 - Applications Access Form Instructions rev. 6/06
 - Applications Access Form rev. 6/06 **SAMPLE**
 - Applications Access Form Attachment
 - Applications Access Form Codes
 - Integrated System Access Roles rev. 01/10/07
- Authorization to Sign CIOB Access Forms rev. 1/10 **SAMPLE**
- DMH Policy 302.18 on "Security and Integrity of the Department's IS" **Confidentiality Oath** ~ **SAMPLE**
- Downey Data Center Registration/Non-County rev. 03/10 **SAMPLE**
- IS Connection Options
- SecurID Renewal Non County and AUP and Sample Form and Sample AUP
- Request for Replacement of Lost PIN
- Request to Change Funding Source on COS

- **Service Delivery Staff**
- Rendering Provider Form PDF rev. 3/14

Link to Data Entry Staff Forms:
http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Required forms, instructions, codes, roles and other helpful information are listed under Integrated System Access.

Sample

Sample Applications Access Form

Applications Access (AAF)

- allows creation of end-user profile in the IS
- role assignments allow client searches, maintain data, medication, reports, etc.
- provider number association restricts access to client's information by provider number association.

Required Signatures :

- User
- Authorized Manager or designee

SUPPORT STAFF Requiring Data Entry Access

APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
CHIEF INFORMATION OFFICE (BUREAU)

REQUEST TYPE

Effective Date
2/15/2004

☒ Add New User

☐ Information Update

☐ Add Reporting Unit

☐ Add Role

☐ Termination

☐ Delete Reporting Unit

☐ Delete Role

☐ Name Change

☐ Transfer

From Location

To Location

EMPLOYEE STATUS

☐ Permanent

☐ Temporary

☐ Pharmacy

☐ FFS

☒ NSA

☐ CHS

APPLICANT INFORMATION

Employee No. (County Only)

Last Name

SWENHARTZ

First Name

CHILD

MI

Last 4 Digits of SSN
1000

Date of Birth MM/DD

Sex Code

Clinicity Code

Handicap Code

Language Code

Name of Facility / Bureau / FFS Network Provider / Pharmacy
SELVED MEDICAL CENTER

Program Name / Unit

PSYCH EMERGENCY

Address

1124 N. HAVEN BLVD

Suite / FL

501

City

HAPPY CITY

State

CA

Zip Code

01234

Phone Number

E-Mail Address

HOWARD@HAPPYHOSP.ORG

ROLE

CLN01

CLN02

RPTPROV

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

☒ DMH Provider No.

12345

☒ NGA Legal Entity No.

1123

☐ CHS Provider No.

☐ Pharmacy

☐ FFS Provider No. (*)

SELECT APPLICATION ACCESS

Integrated System

☒

Day Treatment Authorization

☐

STAR

☐

MAA

☐

MEDS

☐

Oath of Confidentiality on file at Facility

☒

Original Oath Attached with MEDS Request

☐

SIGNATURES

Applicant Print Name

CHILD SWENHARTZ

Signature

SIGNATURE REQUIRED

Date Completed

02/01/04

Contact Print Name

MARY SWENHARTZ

Phone Number

211-266-0123

Date Completed

02/15/04

Program Head / Authorized Designee Print Name

DR. SALLY SWENHARTZ

Signature

SIGNATURE REQUIRED

Form #1

Data Entry Staff

Blank form can be downloaded from the IS link.

This Sample indicates required Information: (All fields)

Downey Data Center Registration Form

Form #2 Data Entry Staff

LOS ANGELES COUNTY
ISD
INTEGRATED SECURITY DEPARTMENT

COUNTY OF LOS ANGELES
DOWNEY DATA CENTER REGISTRATION
For Contractors/Vendors

SAMPLE

PROFILE INFORMATION print or type completing boxes 1-9

(1) DATE OF REQUEST
7/15/2010

(2) TYPE OF REQUEST (Check One) ☐ REPLACE LOST/STOLEN SECURID TOKEN ☐ CONTRACT OR VENDOR NUMBER

(3) ADD NEW LOGON ID ☐ CHANGE LOGON ID ACCESS ☐ DELETE LOGON ID

(4) LAST NAME, FIRST NAME MI
NEVERWRONG, SAMPLE A.

(5) E-MAIL ADDRESS
SNEVERWRONG@PLENT.COM

(6) COMPANY/ORGANIZATION NAME
PLENTY MHS

(7) COORDINATING L.A. COUNTY DEPARTMENT NAME / NUMBER
MENTAL HEALTH - #435

(8) WORK MAILING ADDRESS (STREET, CITY, STATE, ZIP)
2345 Happy Street, Cherry Blossom, CA 90021

(9) WORK PHONE NUMBER
213 201-2000

IBM DATA CENTER ACCESS complete each area for required access, as defined by L.A. County management

(10) LOGON ID

(11) 2-DIGIT MAJOR GROUP CODE
HQ

(12) 3-DIGIT LSO GROUP CODE
MH

☐ TSO ACCESS — check box and complete for required access, as defined by L.A. County management. Asterisks are optional data.

(13) 2-DIGIT TSO GRP CODE

(14) SUB-GROUP 1*

(15) SUB-GROUP 2*

(16) SUB-GROUP 3*

☐ ONLINE ACCESS — check box and complete for required access, as defined by County management. Asterisks are optional data.

(17) SYSTEM APPLICATION
IS

(18) GRP NAME / NATURAL PROFILE

(19) OLD OR NATURAL PROFILE*

(20) APPLICATION COORDINATORS ONLY

(21) APS AO:

(22) DEV SYSTEM CODE:

(23) NEW LOCATION:

UNIX ENVIRONMENT ACCESS complete for required access, as defined by L.A. County management.

(24) TYPE OF REQUEST (Check One) ☐ ADD NEW LOGON ID ☐ CHANGE LOGON ID ACCESS ☐ DELETE LOGON ID

(25) LOGON ID

(26) APPLICATION

(27) ACCESS GROUP

(28) ACCOUNT NUMBER

SECURID REMOTE ACCESS complete as defined by L.A. County mgmt., e-mail address is required, see box #5

(29) BILLING ACCOUNT NUMBER for SecurID Token:

(30) DEVICE TYPE: KEY FOB

☐ VPN

SECURITY STATEMENT

Before connecting to the County network you must install anti-virus software, and stay up-to-date with definitions, Microsoft patches (critical and security) and service packs. A Firewall, either a hardware firewall or personal firewall software, is required for those using broadband Internet access (DSL, ISDN, cable modem, etc.). You agree not to share your login id, password and SecurID passcode with others.

☐ WIRELESS ACCESS Check the box if you are requesting wireless access. APPLICATION:

SIGNATURES each signature entry must be completed in full.

Your signature indicates that you have read and will comply with the above security statement.

(31) CUSTOMER'S SIGNATURE: *Sample D. Neverwrong*

(32) COUNTY DEPARTMENT MANAGER'S SIGNATURE: *Susan B. Neheaven*

(33) PHONE #
213-201-2001

(34) PRINT COUNTY DEPARTMENT MANAGER'S NAME
SUSAN B. NEHEAVEN

(35) DATE
7/15/2010

(36) ISD APPLICATION COORDINATOR'S SIGNATURE: *Joyce A. Fantroy*

(37) PHONE #
213-351-1335

(38) PRINT ISD APPLICATION COORDINATOR'S NAME
JOYCE A. FANTROY

(39) DATE

NOTE: If submitting a PDF, FAX or COPY, this section must be completed in order to process the request.

☐ PDF ☐ FAX ☐ COPY

AUTHORIZED MANAGER NAME: JOYCE FANTROY

AUTHORIZED MANAGER SIGNATURE: _____

NAME (Print) JOYCE FANTROY SIGNATURE: _____

My signature above, stipulates that my department has setup a process to maintain the original form on file for a period of 7 years, and will make the original form available within 72 hours, upon request from ISD or those acting on the behalf of ISD, i.e., internal or external Auditors.

WARNING: FAILURE TO FULLY COMPLETE & SIGN THIS FORM WILL CAUSE A DELAY IN PROCESSING.

SUBMIT TO: COUNTY OF LOS ANGELES/DMH/INFORMATION SECURITY-SYSTEMS ACCESS UNIT

695 SOUTH VERMONT AVENUE, 8TH FLOOR, LOS ANGELES, CA 90005

Revised: March 2010

•Please Do
Not sign
(Field 32)

Downey Data Center Registration, Contractor

- Provides a securID card. Initial authentication to permit end-users through the County's Firewall

- Form must be signed by both the data entry staff (Field 27) and the authorized manager/designee (Field 28).

Agreement For Acceptable Use and Confidentiality of...(AUP)

AUP

•User acknowledgement of confidentiality and violation penalties.

SAMPLE page (page 2) demonstrates that both the data enter staff (user) and authorized manager or designee signature are required.

36 108 144 180 216 252 288 324 360 396 432 468 540

COUNTY OF LOS ANGELES
AGREEMENT FOR ACCEPTABLE USE AND
CONFIDENTIALITY OF
COUNTY INFORMATION TECHNOLOGY ASSETS,
COMPUTERS, NETWORKS, SYSTEMS AND DATA

As a Los Angeles County employee, volunteer or other authorized user of County Information Technology (IT) assets including computers, networks, systems and data, I understand that I accept a portion of what I will use County IT assets for County management approved business purposes only and assume the confidentiality of County's business and County's private data. As a user of County's IT assets, I agree to the following:

- Computer assets:** I am aware of California Penal Code 502(c) - Computerized Computer Data Access and Fraud Act (hereinafter "502(c)"). I will immediately report any suspected computer misuse or abuse to my Manager.
- Security access controls:** I will not share or attempt to share my security credentials or system which has been implemented to control or restrict access to computers, networks, systems or data. I will not share my computer identification codes (log-in ID, computer access codes, accounts, etc., ID's, etc.) or passwords.
- Approved business purposes:** I will use the County's Information Technology (IT) assets including computers, networks, systems and data for County management approved business purposes only.
- Confidentiality:** I will not access or disclose any County program code, data, information or documents as any individual or organization unless specifically authorized to do so by the responsible information owner.
- Computer virus and malware code:** I will not intentionally introduce any computer virus, malware or malicious code into any County computer, network, system or data. I will not download or delete computer virus detection and malicious software on County computers, systems and other computing devices from my workstation.
- Offensive materials:** I will not access or send any offensive materials, e.g., sexually explicit, racial, hateful or insensitive text or images, over County network, local or managed local or wide area networks, including the public Internet and other electronic mail systems, unless it is in the performance of my assigned job duties, e.g., law enforcement. I will report to my supervisor any offensive materials observed by me or sent to me on County system.
- Public Internet:** I understand that the Public Internet is unsecured and contains many sites that may be considered offensive to individuals and groups. I will use County Internet services for approved County business purposes only, e.g., in research and for business communications. I understand that the County's Internet services may be filtered but in any case of them I may be required to affirmatively accept. I agree to hold the County harmless should the unauthorized exposure to such offensive materials. I understand that any business activities may be logged, are publicly viewed, and are subject to audit and review by authorized individuals.
- Electronic mail and other electronic data:** I understand that County electronic mail (e-mail) and data, in either electronic or other form, are a public record and subject to audit and review by authorized individuals. I will comply with County e-mail use policy and use proper business etiquette when communicating over e-mail system.
- Copyrighted materials:** I will not copy any licensed software or documentation except as permitted by the license agreement.

10. **Disciplinary action for non-compliance:** I understand that any non-compliance with any portion of this Agreement may result in disciplinary action including any suspension, discharge, denial of services, cancellation of accounts or both civil and criminal penalties.

CALIFORNIA PENAL CODE 502(c) -
"COMPUTERIZED COMPUTER DATA ACCESS AND FRAUD ACT"

Below is a portion of the "Computerized Computer Data Access and Fraud Act" as it appears specifically in this Agreement. California Penal Code 502(c) is incorporated in its entirety into this Agreement by reference and all provisions of Penal Code 502(c) apply. For a complete copy, consult the Confidentiality in website www.lapda.org/.

502 (c) Any person who commits any of the following acts is guilty of a public offense:

- (1) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer, computer system, or computer network in order to obtain (A) information or cause any alteration or deletion of data, or (B) damage to or destroy any data, program, or data.
- (2) Knowingly accesses and without permission alters, copies or makes use of any data from a computer, computer system or computer network, or alters or copies any information, document, or other data or information stored or received on a computer, computer system, or computer network.
- (3) Knowingly and without permission uses or causes to be used computer services.
- (4) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer system, or computer program which is received or transmitted on a computer, computer system, or computer network.
- (5) Knowingly and without permission disrupts or causes the disruption of computer services or data or causes the denial of computer services to an authorized user of a computer, computer system, or computer network.
- (6) Knowingly and without permission provides or causes to be provided a means of accessing a computer, computer system or computer network in a violation of this section.
- (7) Knowingly and without permission accesses or causes to be accessed any computer, computer system, or computer network.
- (8) Knowingly introduces any computer contamination into any computer, computer system, or computer network.

I HAVE READ AND UNDERSTAND THE ABOVE AGREEMENT.

SAMPLE KEMERWORTH SAMPLE KEMERWORTH 7/15/2010
Employee's Name Employee's Signature Date

SUSAN B. MYHEAVEN Susan B. Myheaven 7/16/2010
Manager's Name Manager's Signature Date

Form #3
Data Entry Staff

Data entry staff (user) and authorized manager or designee must sign this form.

Confidentiality Oath

36 72 108 144 180 216 252 288 324 360 396 468 504

SAMPLE

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CIO Bureau/Information Security/Systems Access Unit

CONFIDENTIALITY OATH

The intent of this Confidentiality Form is to ensure that all County, Contractor, Pharmacy, Non-Governmental Agency (NGA), and Fee-For-Service (FFS) Network Provider employees are aware of their responsibilities and accountability to protect the confidentiality of clients' sensitive information viewed, maintained and/or accessed by the IT on-line systems.

Further, the Department's Medi-Cal and MHDS access policy has been established in accordance with Federal and State laws governing confidentiality.

Workers and Institutions (W&I) Code, Section 14100.2, cites the information to be regarded confidential. This information includes applicant/beneficiary names, addresses, services provided, social and economic conditions or circumstances, agency evaluation of personal information and medical data. (See also 22 California Code of Regulations (C.C.R.), Sections 50111 and 51009.)

The Medi-Cal Eligibility Manual, Section 2-H, titled "Confidentiality of Medi-Cal Case Records," referring to Section 14100.2, a, b, f and h, W&I Code, provides in part that:

"(a) All types of information, whether written or oral concerning a person made or kept by any public office or agency in connection with the administration of any provision of this chapter, shall be confidential and shall not be open to examination other than for purposes directly connected with administration of the Medi-Cal program."

"(b) Except as provided in this section and to the extent permitted by Federal Law or regulation, all information about applicants and recipients as provided for in subdivision (a) to be safeguarded includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation of personal information and medical data, including diagnosis and past history of disease or disability."

"(c) Requires agents of the State to abide by rules and regulations governing the custody, use and preservation of all records pertaining to administration of the Medi-Cal program."

"(h) States "any person who knowingly misuses or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits...for which State or Federal funds are made available in violation of this section is guilty of a misdemeanor."

Please read the agreement and take due time to consider it prior to signing.

I understand County, Contractor, Pharmacy, NGA, and FFS employees are prohibited from sharing their unique Log-on ID and password with co-workers or other agencies.

Further, I understand County, Contractor, Pharmacy, NGA, and FFS employees are prohibited from obtaining, making or using confidential client information from case records or computer records for purposes not specifically related to the administration of services and authorized by the state Workers and Institutions Code (Section 14100.2).

Further, I understand violation of confidentiality of records or of these policies which are made for protection of confidentiality, may cause:

1. A civil action under the provision of the Workers and Institutions Code Section 5330 or of Chapter 3 (commencing with Section 4330) of Part 1 of Division 4, for the greater of the following amount:
 - 1.) Ten thousand Dollars (\$10,000)
 - 2.) Three times the amount of actual damage, if any sustained by the plaintiff.
2. Disciplinary action including suspension or termination of employment.

Further, I understand that the County will not provide legal protection if violations of these policies or procedures occur.

I hereby certify that I have read this form and the Department of Mental Health Policy on Security and Integrity of Management Information System Data. I have knowledge of the requirements of state and federal confidentiality laws and will comply with its provisions.

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Workers and Institutions Code, Section 5326, et seq.

User's Name: CHILD SNOWWHITE Child Snowwhite
Print Signature

Employee #: _____ Phone # (213) 200-2000 Ext. _____

Pharmacy, FFS, NGA Legal Entity Name: _____
 Provider #: 12345 Provider Name: PLENTY Mental Health Services

Address: 2345 Happy Street / Cherry Blossom / 90021
City State Zip

Service Area: 5 Date: 3/14/2007

CIO USE ONLY
 Approved By: NEED SIGNATURE Date: _____
See and 1-4-07 - Confidential Data policy, Document

Keep This Form On File At Your Facility

Form #4
Data Entry Staff
Maintain By Provider

Data Entry staff (User) must agree to established measures to safeguard sensitive and confidential data (PHI).

Provider must maintain this form in an office file and must be made available during audits and/or investigations.

Rendering Provider

Service Delivery Provider

- ***The Rendering Provider Form must be completed for all clinical staff members who are new or are not on the Integrated System. Rendering Provider must be associated at a provider location for claim submission purposes.***
- ***This form is to authorize association and is also to be used for clinical staff that have terminated services from a provider location or to update information, i.e., name change, license renewal, taxonomy, reporting unit effective date, or expiration dates.***
- ***When completing this form, please refer to the following guidelines:***
 - The original form must be completed in its entirety (if applicable), with the required signature. Fax, photocopy and/or e-mail forms are not acceptable.
 - All information must be current upon submission of this form.
 - Be sure all fields are completed accurately and appropriately to avoid delay in the processing of a request.
 - Forms, instructions, taxonomy codes (discipline codes), etc are posted on the Integrated Systems website at: http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Rendering Provider

Service Delivery Provider

➤ Required Form

Required

- Rendering Provider Form

- Critical Information

Rendering Provider Form Instructions

• Taxonomy Codes and Description

- Authorized signer

• No “on behalf of” signatures

Microsoft PowerPoint - [PPP IS Summary]

template - Windows Internet Explorer

http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

File Edit View Favorites Tools Help

template

IS HOME DIRECTLY OPERATED CLINICS OUTPATIENT FEE-FOR-SERVICE CONTRACT PROVIDERS

Working in the IS ← → IS Forms

Special Bulletins!

Getting Started on the IS

Getting IS Training

Using the IS

Using IS Reports

Handling Error Msgs. & Denials

IS Forms

Clinical Forms

Co-Occurring Disorders Forms

Getting Help with the IS

Links

EDI / Secure File Transfer

Want to order Forms from the DMH Warehouse? 213-738-4769

These forms are for Contract Providers
~ Face Sheets/Billing Forms ~

Procedures for Forms

- **Integrated System Access**
Applications Access Form Instructions rev. 6/06
Applications Access Form rev. 6/06 SAMPLE
Applications Access Form Attachment
Applications Access Form Codes
Integrated System Access Roles rev. 01/10/07
- Authorization to Sign CIOB Access Forms rev. 1/10 SAMPLE
DMH Policy 302.18 on "Security and Integrity of the Department's IS"
Confidentiality Oath ~ SAMPLE
Downey Data Center Registration/Non-County rev. 03/10 SAMPLE
IS Connection Options
- SecurID Renewal Non County and AUP and Sample Form and Sample AUP
Request for Replacement of Lost PIN
Request to Change Funding Source on COS
- **Service Delivery Staff**
Rendering Provider Form PDF rev. 3/14
Rendering Provider Form Attachment rev. 2/07
Rendering Provider Form Instructions rev. 11/08
Rendering Provider NGA Sample rev. 3/14
Rendering Provider NPI Updates Sample
Rendering Provider License Update Sample
Taxonomy Codes and Descriptions

Link to Rendering Provider Forms:
http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Required forms, instructions, discipline codes, and other helpful information are listed under Service Deliver Staff

Sample

Rendering Provider Sample Form

Missing information will delay processing

Rendering Provider Form is required to allow Providers to submit claims for client's services.

Authorized Manager or designee signature is required

•No "on behalf of" signatures

N G A S A M P L E

RENDERING PROVIDER FORM

Mail to: Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 South Vermont Avenue
Los Angeles, CA 90005

Request Type

Submit Date: 041107 ☒ New ☐ Update ☐ License ☐ Terminate ☐ Name Change

General Information

Last Name: PEACEMAKER
First Name: NOEL
Middle Initial: S Sex: [F] Ethnicity: []
DMH/NGA Staff Code: H M H 0 2 1 3
PFS Ind Prov No: [] [] [] [] [] [] [] []
SSN (Last 4 only): 0 2 0 2
Language Code: 0 1 [] [] [] [] [] [] [] []

Select DMH Classcode:
☐ DMH
Prov name: [] [] [] [] [] [] [] []
☐ DHS
Prov name: [] [] [] [] [] [] [] []
☒ Non-Governmental Agency (DMH Contracted)
L.E.#: US 14
L.E. Name: HAVEN MH ASSOC.
☐ PFS Individual ☐ PFS Group ☐ PFS Org
Tax Payer ID (PFS only): [] [] [] [] [] [] [] []

Contact & Assigned Location Information

Contact name: JANE NEWBERRY Contact Email: newberry@sample.net
Contact phone no: (211) 256-0123 Contact Fax No: (211) 256-1430
☒ Add this rendering provider to the service location indicated below (please use form MH-228A for additional locations)
☐ Delete this rendering provider to the service location indicated below ☐ Delete this rendering provider in ALL service locations unless the box is not indicated above.
DMH/NGA Prov No/Regt Unit: 7 1 9 2 A PFS Group/Org Prov No: [] [] [] [] [] [] [] []
(Please enter the provider no. associated to the above tagayer ID)
Effective Date: 041107 Termination Date: [] [] [] [] [] [] [] []
Locum Tenens ☐ Intern ☐
Name of Organization: HAVEN MENTAL HEALTH ASSOC. Service Area: [] MHSA ☐
Address: 4231 NEW ATTITUDE BLVD City: RAGE TOWN Zip: 02346

Taxonomy and License Information (Required if request type is NEW)

Description: PHYSICIAN, PSYCHIATRY Taxonomy: 2 0 8 4 P 0 8 0 0 X
Professional License #: 0 1 0 2 3 8 9 1 Effective Date: 0 1 0 1 0 7 Expiration Date: 0 1 0 1 1 0
Description: [] [] [] [] [] [] [] [] Taxonomy: [] [] [] [] [] [] [] []
Professional License #: [] [] [] [] [] [] [] [] Effective Date: [] [] [] [] [] [] [] [] Expiration Date: [] [] [] [] [] [] [] []
DEA License #: B B 2 2 2 2 2 2 2 2 Expiration Date: 0 1 0 1 1 0
Medicare Prov No: [] [] [] [] [] [] [] [] PPN Medicare No: [] [] [] [] [] [] [] [] Expiration Date: [] [] [] [] [] [] [] []
(DMH directly operated only) (DMH directly operated only)
NPI: 1 2 3 6 7 0 2 8 5 1 NPI Effective Date: 0 4 0 2 0 7

Authorized Manager or designee Signature: [] [] [] [] [] [] [] [] SIGNATURE REQUIRED Print Name: BEGONE JANUARY Date: 4/11/07

DOB USE ONLY

Rendering Provider ID No: [] [] [] [] [] [] [] [] Ticket #: [] [] [] [] [] [] [] []
Date Processed: [] [] [] [] [] [] [] [] Processed by: [] [] [] [] [] [] [] []

Revised: 3/14/2007 MH-228

Rendering Provider Form

➤ Submission Method

1. Hard copy — fillable form posted at
http://www.lacounty.gov/hipaa/cp_ISForms.htm
2. Automation — online completion and submission
 - Submit “Individual Authorized to Sign CIOB Form”
 - Provider sent automation link and instructions
 - Benefits
 - “Go Green” - Save paper, ink, postal stamps, etc
 - Receipt confirmation
 - Timely processing and notification
 - Minimal incorrect form submission. Form designed according to Request Type.



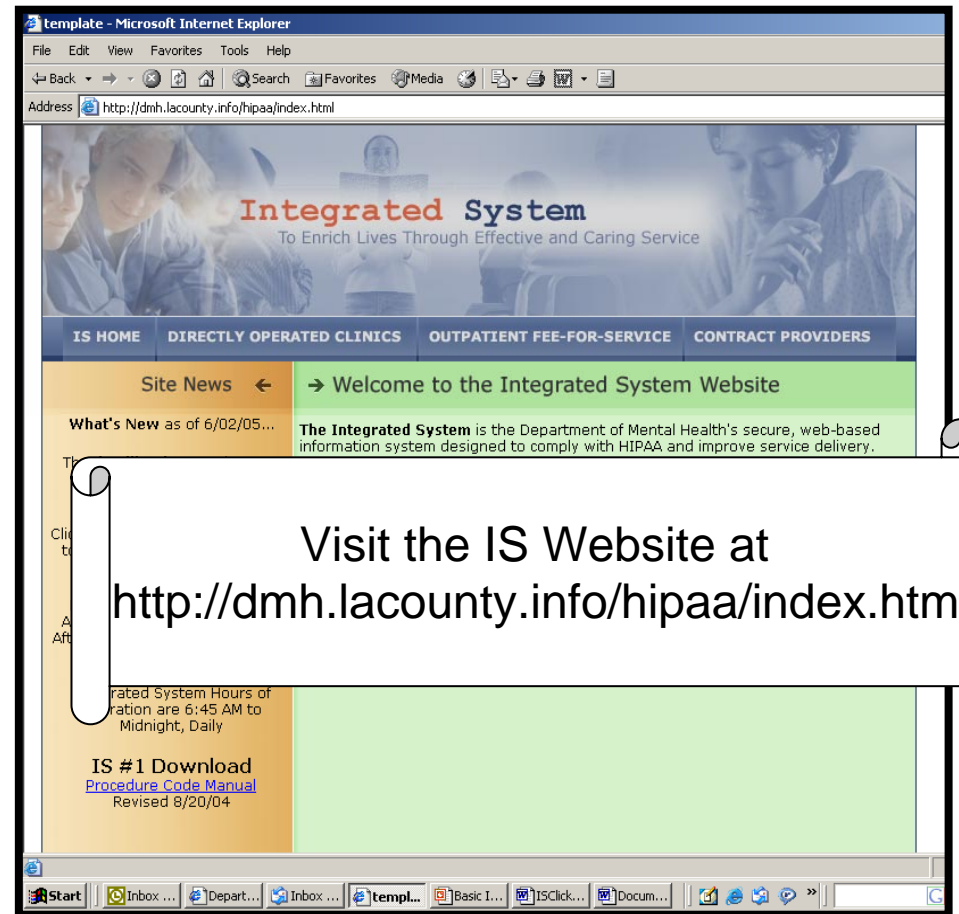
Getting Help

- Contact CIOB/Help Desk at 213-351-1335 to reach a member of the Systems Access Unit team.

Basic Integrated System (IS) Training

Things to Keep in Mind

- All Patient Health Information (PHI), in this manual, is fictitious.
- Remember to use the help (?) icon.
- It is recommended that you understand the billing processes before using the IS.
- To return to the previous screen, always click on the Return button, under Options.
- Italicized fields must be completed.
- Dates must be entered as: 00/00/0000
- You will be logged off every 15 minutes when not using the system; you will have to click on the Home page to log back in.
- It is strongly recommended that you attend the PATS training on medications.
- You only have access to the Home and Clinical pages of the System
- MIS, IS, and DMH number are all the same.



Basic IS Training

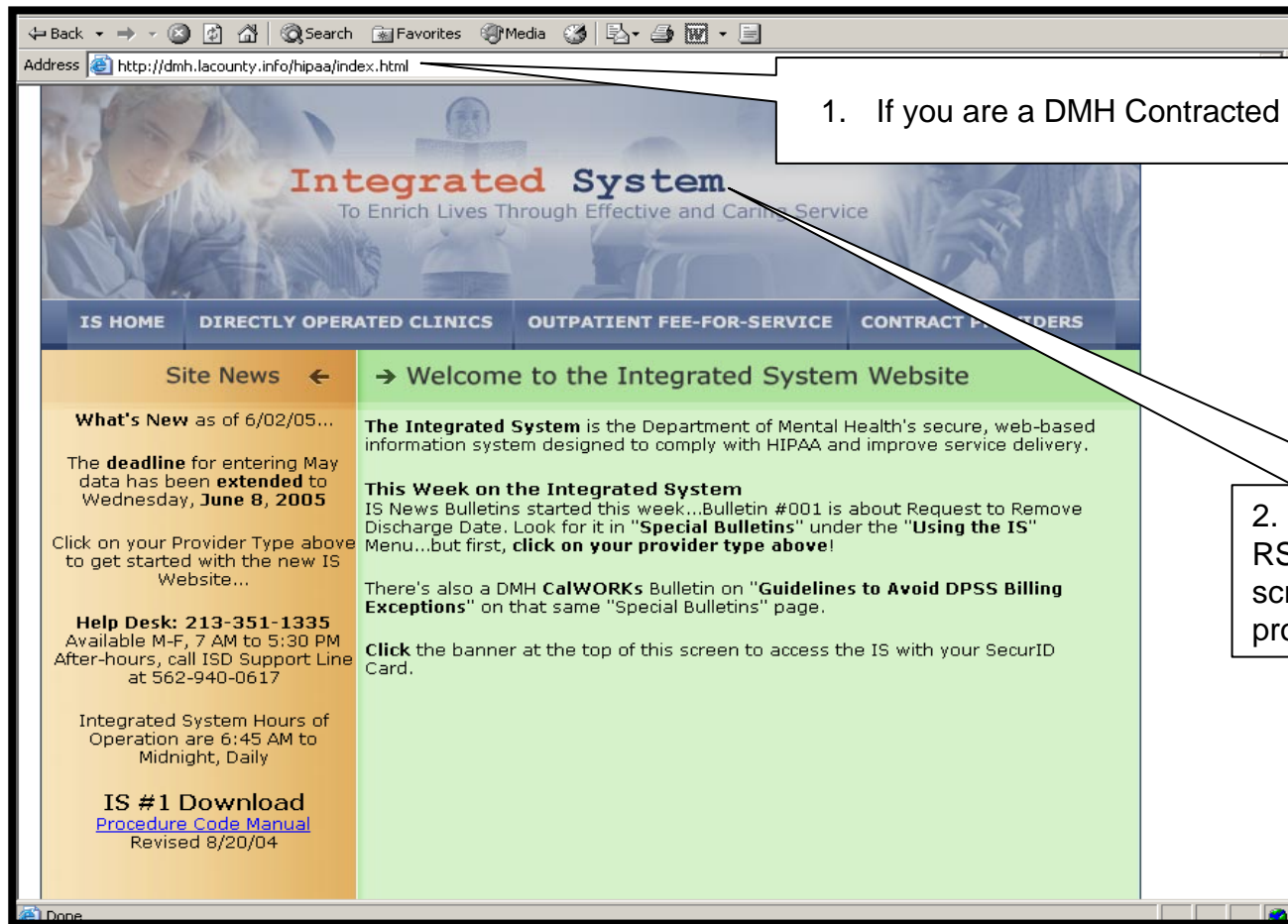
1. Log in
2. Find a Client
3. Add a Client: Identification Screen
4. Add a Client: Contacts Screen
5. Add a Client: Financial Screen
6. Add a Client: Other Screen
7. Open an Episode: Admission Screen
8. Open an Episode: Diagnosis Screen
9. Add Services
10. Add a Claim, a Plan and Payer (s)
11. Void and Replace a Claim
12. Close an Open Episode: Discharge and Diagnosis Screens

Use Keyboard Shortcuts!

Avoid using the Mouse.

- The Tab key will take you through every field on the screen.
- Shift-Tab will take you backwards through those fields.
- Down Arrows and characters to go through drop-down lists.
- The Space bar will check and uncheck boxes.
- The Enter key will activate buttons.

Log In with a SecurID Card



Add a Client: Contact Information

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH | Home | **Clinical** | Administrative | Plan | CIOB

7100-SFV CMHC CENTE:7100A-SFV CM | jgarciaabagues [X]

Client Information

Client: TestClient , Example (not enrolled) ?

Options

- Return
- Change Provider
- Find Client
- Daily Log
- View Episodes
- Check Eligibility
- Enroll Client
- Eligibility History

Identification | **Contacts** | Financial | Other | Groups

ClientAddress

Transient/Homeless ☐ Time Homeless: []

Address 1: [160 Example Street] Address 2: []

City: [Los Angeles] County: [] State: [CA] Zip: [90005]

Phone: (h) [(213)121-1212] (w) []

Address Memo: []

Other Contacts

	Name	Type	Phone	Email	Add'l Details
+					
1					

Click to add other contacts

Click

Cancel Continue

Address is required if the client is not homeless

Add a Client: Financial Information

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH

Home Clinical Administrative Plan CIOB

7100-SFV CMHC CENTE:7100A-SFV CMHC jgarciabagues

Client Information

Client: TestClient , Example (not enrolled)

Options

- Return
- Change Provider
- Find Client
- Daily Log
- View Episodes
- Check Eligibility
- Enroll Client
- Eligibility History

Identification **Contacts** **Financial** **Other** **Groups** **XRef** **MCaI Benefits**

UMDAP Date: 02/08/2008

Service Location:

Family Income (\$): 300.00

Source of Income: SSI

of Dependents: 1

Annual Liability (\$): 0.00

Client Reported Benefits

Type	Description	ID Number

Click to add Medi-Cal or Other benefits

This field is for client's initial or annual UMDAP date

Cancel Continue

Add a Client: Benefit Information

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH

Home Clinical Administrative Plan CIOB

7100-SFV CMHC CENTE:7100A-SFV CMHC jgarciabagues

Benefit Information

Client: TestClient , Example (not enrolled) ?

Options

Return

Type:

Description:

HMO/PHP:

ID Number:

Champus
Client/Family
HMO/PHP
Insurance/Third Party
Medicare
Other County
SD/Medi-cal

Select benefit type

Cancel Save

Open an Episode: Admission Screen

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH

Home Clinical Administrative Plan CIOB

7100-SFV CMHC CENTE:7100A-SFV CMHC jgarciabagues

Client Information

Client: TestClient , Example () ?

Options	Identification	Contacts	Financial	Other	Groups	XRef	MCal Benefits
Return	Name Last: TestClient			First: Example		Middle:	
Change Provider	AKA Last:			First:		Middle:	
Find Client	IM Name:			LOC:			
Daily Log	DOB: 07/12/1970			Age: 37			
View Episodes	Primary Lang: 01-English			Pref Lang: 01-English			
Check Eligibility	Marital Status: 01-Single			Education: 12-Twelfth Grade			
Enroll Client	Ethnicity: 01-White			Tribe:			
Eligibility History	Origin:			Employment: FC-Full time competitive employment (salaried)			
	Handicap: 00-Not physically disabled/no significant disability						
	Living Arrngmnt: 01-Lives alone in house or apartment						
	Conservatorship:			Veteran: No			
	Date Of Death:			English Speaking: <input checked="" type="checkbox"/>			
				Cancel			Continue

Click to view a client's episode

Add Services

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH

Home Clinical Administrative Plan CIOB

7100-SFV CMHC CENTE:7100A-SFV C jgarciabagues

Outpatient Episode

Client:TestClient,Example() ?

Options

- Return
- Find Client
- Client Info
- Check Eligibility
- Medications
- Close Episode
- View Episodes

Search Service Date

From Date

To Date

Search

Services Void Services Diagnosis Admission

	Service Date	POS	Total Time	# Staff	Procedure	Rendering Provider	M	S	C	D
+										
1										

Click to begin entering a service

Add Services

■ What is Evidence-Based Practice/Service Strategies/PEI Services?

They are techniques that use research results, reasoning, and best practices to inform the improvement of Mental Health Care. DMH is now using the IS to track the use of these techniques. These are some examples: Multisystemic Therapy, Functional Family Therapy, Brief Strategic Family Therapy, Functional Family Therapy, Peer and/or Family Delivered Services, Family Support

Add Services

Evidence Based Practice:

- 00-No EBP/SS
- 01-EBP ACT
- 10-EBP MST
- 11-EBP FFT
- 2A-Brf Strat FamTher
- 2B-CPP Chld-Prnt Ther

The system may allow you to select up to 3 options

CP's must use 2K Impact

Evidence Based Practice:

- 2F-DTQI-Dep Treat QI
- 2J-Group CBT Maj Dep
- 2K-IMPACT**
- 2L-Incredible Years
- 2M-IPT Depression
- 2P-Multidim Fam Ther

Add a Claim: Add a Plan

Los Angeles COUNTY | DEPARTMENT OF MENTAL HEALTH

Home Clinical Administrative Plan CIOB

1904-ANTELOPE V:1904A-ANTELOPE

Add Outpatient Claim

Client: TestClient, Example() ?

Options

Return

Check Eligibility

Service

Client Benefits: [Dropdown]

Staff Code: E232633

Service Date	Procedure	Mod1	Mod2	Unit Type	Units	Rate
03/12/2011	90801			MJ	84	3.16

Claim Amount: 265.44 Late Code: [Dropdown]

SOC Obligation: [Dropdown] Medi-Cal ☐ EVC: [Dropdown] SED Healthy Families ☐

Service Facility Address ☐ EPSDT Scr Ref ☐ Emergency ☐ Pregnancy ☐ Dup Override ☐

Claim Plans:

Plan	Pay Order
+	
1	

Medicare / Other Insurance:

Payer	Paid Amount	SubscriberID
+		
1		

Submit Save Cancel

Add a Claim: Add a Plan

COUNTY DEPARTMENT OF MENTAL HEALTH Home Clinical Administrative Plan CIOB

1904-ANTELOPE V:1904A-ANTELOPE

Plan ?

Options Client Benefits SD/Medi-cal:97671909C Staff Code: LCA0934

Return ServiceDate Procedure Mod1 Mod2 UnitType Units



02/04/2011 90801 MJ 27

Plans: PEI_Special_Programs [07/01/2010-12/31/2020]

Pay Order: Alt_Crisis_svc-Urgent_Care_Ctr [07/01/2009-12/31/2020]
 CalWORKs [07/01/2002-12/31/2020]
 CGF [07/01/2002-12/31/2020]
 FCCS-ADULT MHSA [04/01/2008-12/31/2020]
 FCCS-OLDER ADULT MHSA [03/06/2007-12/31/2020]
 GROW [07/01/2002-12/31/2020]
 MHSA_Fam_Focused_Wellness_Svc [01/01/2007-12/31/2020]
 PEI_Adult [07/01/2010-12/31/2020]
 PEI_Children [05/11/2010-12/31/2020]
 PEI_Older_Adult [07/01/2010-12/31/2020]
 PEI_Special_Programs [07/01/2010-12/31/2020]
 PEI_TAY [05/11/2010-12/31/2020]

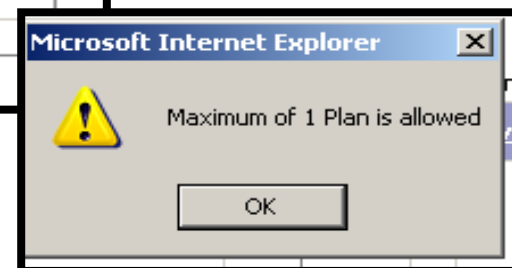
CP's must use PEI-Special Programs

Claim Plans:

	Plan	Pay Order
	CGF	1
		

If you click to add a second plan per claim, the IS will generate this error message

This means that your plan was added



Add a Claim

Los Angeles
COUNTY

DEPARTMENT OF MENTAL HEALTH

Home

Clinical

Administrative

Plan

CIOB

1904-ANTELOPE V:1904A-ANTELOPE

Add Outpatient Claim

Client: Client:TestClient, Example ()

?

Options

Return

Check Eligibility

Service

Client Benefits

Service Date

Procedure

Mod1

Mod2

Unit Type

Units

Rate

Staff Code:

E232633

03/12/2011

90801

MJ

84

3.16

Claim Amount:

265.44

Late Code:

SOC Obligation:

Medi-Cal

☐

EVC:

SED Healthy Families

☐

Service Facility Address

☐

EPSDT Scr Ref

☐

Emergency

☐

Pregnancy

☐

Dup Override

☐

Claim Plans:

Medicare / Other Insurance:

	Plan	Pay Order	
	CGF	1	
1			

	Payer	Paid Amount	SubscriberID	
	Other1	0.00	3545	
1				

Submit

Save

Cancel

CLAIMING AND REIMBURSEMENT

COMMUNITY PARTNER AGENCIES

LACDMH Claiming for HWLA Enrolled Clients – DRAFT 6/29/11

General Guidelines:

Community Partner agencies are contracted with LACDMH solely to provide Mental Health Integration Program (MHIP) / IMPACT services to “Tier 2” service need individuals who are enrolled in and eligible for Healthy Way LA (HWLA). Payments for services are provisional.

- If it is determined that a client was not eligible/enrolled in HWLA at the time of service, LACDMH will recoup any payments made for that service.
- A client contact should only be claimed as a “visit” if the contact is face-to-face and at least 20 minutes in duration
- Community Partners are limited to receiving payment for only 1 visit on any given day for an enrolled client. If it is determined that an agency was paid by both DMH and DHS for same day visits by a HWLA enrolled/eligible client, the County (DMH or DHS) will recoup payment for any visits in excess of the one (1) reimbursable visit.

Prior to claiming for these services, a client record for the individual must exist (identified via a client search) or be created in the LACDMH IS (Integrated System). New client records should never be created when the individual has an existing client record in the IS. In addition, a treatment episode at the provider’s service location must be opened for that client. For all eligible HWLA enrollees who receive Tier 2 services, their claims on the IS must have: 1) the proper procedure code; 2) the appropriate PEI IS Plan; and 3) the correct EBP selected:

- 1) All Community Partner service claims must only use the **H2016** procedure code. The “Units” claimed are always one (1).
- 2) All clients served by Community Partner agencies must be associated to the **“PEI Special Programs”** IS plan.
- 3) Services delivered under the Mental Health Integration Program (MHIP) must be claimed using the IS Evidence Based Practice field **“2K – IMPACT”**. No other/additional EBPs or Service Strategies should be selected from the Evidence Based Practice menu on the IS service screen.

The Primary Care Provider at the Community Partner agency is responsible for medication support and medications provided to Tier 2 HWLA clients and are claimable to DHS not DMH.. However, costs associated with the services of the MHIP consulting psychiatrist should be billed via invoice to DMH as per the contract and established procedures.

HWLA enrolled/eligible Tier 2 clients may receive up to 6 mental health visits within a 12-week period without authorization. If authorization for additional visits is anticipated, a request for such authorization should be submitted to the LACDMH authorization unit prior to the fifth visit. As this authorization system is still in development, LACDMH may engage in claim-based utilization review to monitor compliance as an interim measure. In addition, LACDMH may review information recorded on the IMPACT Registry, when implemented, in the context of utilization review and determination of over threshold authorization.

LEGAL ENTITY CONTRACT AGENCIES

LACDMH Claiming for HWLA Enrolled Clients – DRAFT 6/27/11

General Guidelines:

Legal Entity providers will claim services using existing procedure codes and rates (see exceptions/limitations related to Tier 2 group and medication services).

If a client is subsequently determined to have been ineligible for HWLA at the time of service due to receiving retroactive Medi-Cal covering the period of service, the LE may void and rebill those services to Medi-Cal provided that they have available matched funds in their contract and the LE determines that the services provided are Medi-Cal billable and that documentation meets the standards outlined in the Organizational Provider's Manual.

Tier 1 Guidelines:

The IS plan used for services delivered to Tier 1 clients would be based on the specific services being delivered to the client within that LE's available programs and plans for unmatched services (e.g., a 36-year-old HWLA-enrolled client being served in the LE's FSP program would be claimed to the "FSP Adult" IS Plan with the Medi-Cal box unchecked for DDE IS users / No "Other Payor" for EDI providers).

While there is no "per client" cap on the amount or duration of services delivered to HWLA Tier 1 clients, the amount of service overall is limited to the Maximum Costs Allowable (MCA) in their Legal Entity contract for the appropriate Tier 1 program.

If a Tier 1 client is determined to lack or have lost HWLA eligibility, the LE can continue to provide services to that client the extent they have unmatched funds available and continuation of services is clinically appropriate.

Tier 2 Guidelines:

The "**PEI Special Programs**" IS Plan is to be used for Tier 2 HWLA clients.

Services delivered under the Mental Health Integration Program (MHIP) should be claimed using the IS Evidence Based Practice field "**2K – IMPACT**". Note that HWLA Tier 2 Legal Entity providers may begin providing Tier 2 HWLA services prior to obtaining training in the specific Problem Solving approach typically associated with MHIP. Pending receipt of training in MHIP Problem Solving, interventions from other short-term PEI-included EBP's on which they have been trained (e.g., Benjamin Rush model crisis intervention, techniques from Seeking Safety) can be used within the context of MHIP. When these interventions are used as a Tier 2 service for a HWLA enrollee, such services should still be claimed using the IS Evidence Based Practice field "**2K – IMPACT**". No other EBPs should be selected from the drop down menu for HWLA Tier 2 clients.

LEGAL ENTITY CONTRACT AGENCIES

LACDMH Claiming for HwLA Enrolled Clients – DRAFT 6/27/11

Procedures covered for Tier 2 clients include individual psychotherapy and rehabilitation, psychiatric diagnostic assessment, targeted case management, and team conference/case consultation.

Group, Medication Support Services, and Medication costs for Tier 2 HwLA client should NOT be claimed to LACDMH. The Primary Care Provider at the Community Partner agency is responsible for medication support and medications provided to Tier 2 HwLA clients. In some instances, the MHIP consulting psychiatrist may feel a need to conduct a face-to-face evaluation of a Tier 2 client in order to provide more detailed feedback to the Primary Care Provider or MHIP treatment team. This visit would most likely be claimed as a Psychiatric Diagnostic Assessment – 90801.

If a Tier 2 client is determined to lack or have lost HwLA eligibility for a reason other than they client having gained Medi-Cal eligibility, the LE shall have 1 additional session to terminate services in a clinically appropriate manner.

Tier 2 clients may receive up to 6 “visits” within a 12-week period without authorization. In this context, a visit is defined as one or more claimed services delivered on the same day. If authorization for additional visits is required, a request for such authorization should be submitted to LACDMH prior to the fifth visit. As this authorization system is still in development, LACDMH may engage in claim-based utilization review to monitor LE compliance as an interim measure. In addition, LACDMH may review information recorded on the IMPACT Registry, once implemented, in the context of utilization review and determination of over threshold authorization.

Certain start-up costs may be covered by invoice. Separate guidelines will be issued to address this topic.

LACDMH DIRECTLY OPERATED PROGRAMS

LACDMH Claiming for HWLA Enrolled Clients – DRAFT 6/27/11

General Guidelines:

DMH Directly Operated programs will claim services using existing procedure codes and rates (see exceptions related to Tier 2 group and medication services).

If a client is subsequently determined to have been ineligible for HWLA at the time of service due to receiving retroactive Medi-Cal covering the period of service, the provider should void and rebill those services to Medi-Cal if it is determined that the services provided were Medi-Cal billable and that documentation meets the standards outlined in the Organizational Provider's Manual and DMH policy.

Tier 1 Guidelines:

The IS plan used for services delivered to Tier 1 clients would be based on the specific services being delivered to the client within that clinic's available programs and plans (e.g., a 36-year-old HWLA-enrolled client being served in an FSP program would be claimed to the "FSP Adult" IS Plan with the Medi-Cal box unchecked).

There is no "per client" cap on the amount or duration of services delivered to HWLA Tier 1 clients.

If a Tier 1 client is determined to lack HWLA eligibility for a reason other than the client having gained Medi-Cal eligibility, the Directly Operated program can continue to provide services as clinically appropriate.

Tier 2 Guidelines:

The "**PEI Special Programs**" IS Plan is to be used for Tier 2 HWLA clients.

Services delivered under the Mental Health Integration Program (MHIP) should be claimed using the IS Evidence Based Practice field "**2K – IMPACT**". Note that DO programs may begin providing Tier 2 HWLA services prior to obtaining training in the specific Problem Solving approach typically associated with MHIP. Pending receipt of training in MHIP Problem Solving, interventions from other short-term PEI-included EBP's on which they have been trained (e.g., Benjamin Rush model crisis intervention, techniques from Seeking Safety) can be used within the context of MHIP. When these interventions are used as a Tier 2 service for a HWLA enrollee, such services should still be claimed using the IS Evidence Based Practice field "**2K – IMPACT**". No other EBP's should be selected from the drop down menu for HWLA Tier 2 clients.

LACDMH DIRECTLY OPERATED PROGRAMS

LACDMH Claiming for HWLA Enrolled Clients – DRAFT 6/27/11

Procedures for Tier 2 clients include individual psychotherapy and rehabilitation, psychiatric diagnostic assessment, targeted case management, and team conference/case consultation.

The Primary Care Provider at the Community Partner/DHS Primary Care provider agency is responsible for medication support and medications provided to Tier 2 HWLA clients. For Tier 2 HWLA clients receiving MHIP services, it is expected that Group and Medication Support Services would not be provided by the Directly Operated mental health service provider. In some instances, the MHIP consulting psychiatrist may feel a need to conduct a face-to-face evaluation of a Tier 2 client in order to provide more detailed feedback to the Primary Care Provider or MHIP treatment team. This visit would most likely be claimed as a Psychiatric Diagnostic Assessment – 90801.

If a Tier 2 client is determined to lack HWLA eligibility for a reason other than the client having gained Medi-Cal eligibility, the program can provide 1 additional session to terminate services in a clinically appropriate manner. (Separate guidelines will address the issue of when Tier 2 clients can be moved to Tier 1 services)

Tier 2 clients may receive up to 6 “visits” within a 12-week period without authorization.

In this context, a visit is defined as one or more claimed services delivered on the same day. If authorization for additional visits is required, a request for such authorization should be submitted to the LACDMH authorization unit prior to the fifth visit. As this authorization system is still in development, LACDMH may engage in claim-based utilization review to monitor compliance as an interim measure. In addition, LACDMH may review information recorded on the IMPACT Registry, when implemented, in the context of utilization review and determination of over threshold authorization.



Claiming and Reimbursement

Financial Services Bureau



Agreement

- DMH will contract with Community Partners (CP) to provide MHIP specialty mental health services to HWLA enrolled clients.
- DMH will reimburse CP for specialty mental health services, clinical consultation, training and one-time start-up cost.



Claiming/Reimbursement

Specialty Mental Health Services

- DMH will reimburse CP for 6 or less “billable visits” in a 12 week period starting with the Episode Admission Date for HWLA clients.
- Reimbursement for additional visits will require an approved Treatment Authorization Request (TAR).



Claiming/Reimbursement

- CP that are FQHCs and FQHC lookalikes that have mental health within their scope of project will be reimbursed for a maximum of one “billable visit” per day per client, regardless of the number of mental health and non mental health visits provided.
- CP that are FQHCs and FQHC lookalikes that do not have mental health within their scope of project and non FQHCs may be reimbursed for up to two “billable visits” per day per client, provided one visit is for specialty mental health and the other is for medical services.



Claiming/Reimbursement

- A “billable visit” is defined as a face-to-face encounter between the HWLA client and a mental health professional.
- A “billable visit” must be 20 minutes of which 15 minutes must be face-to-face time.
- CP must submit HIPAA compliant electronic claims for “billable visits” in the DMH IS for reimbursement.
- Claims must be submitted within 15 calendar days after the end of the month in which services were rendered.



Claiming/Reimbursement

- The reimbursement rate for the CP's "billable visit" will be either the Medi-Cal Prospective Payment System (PPS) rate or \$109.00 per billable visit, whichever is greater.
- Reimbursement will be made monthly to the CP.
- Payment schedule will be provided indicating the claim cut off date and warrant issuance date.



Claiming/Reimbursement

- Monthly payments will reflect offsets for disallowed claims, such as:
 - Non-HWLA enrollees
 - Clients who are Medi-Cal eligible
 - Claims submitted after the timeframe allowed
 - Same day services that do not follow the guidelines previously discussed.
 - Failure to submit or obtain an approved Treatment Authorization Request (TAR) for additional visits.



Claiming/Reimbursement

- An annual reconciliation will also be performed for the disallowances above and to cover the protocol set forth by DMH and DHS for same day specialty mental health and medical service visits.
- Reports detailing the approved and disallowed claims will be available for each CP.



Claiming/Reimbursement

Clinical Consultation

- MHIP requires the review of patient progress and revising treatment plans when necessary.
- DMH will reimburse CP for manual/paper invoices submitted for clinical consultation by a licensed and Board Certified Psychiatrist.



Claiming/Reimbursement

- DMH will reimburse CP at the rate of \$200 per hour for a maximum of 2 hours per week for clinical consultation.
- CP must submit invoices for clinical consultation within 15 calendar days after the end of the month in which services were rendered.



Claiming/Reimbursement

Training/One-Time Costs

- DMH will reimburse CP for manual/paper invoices for staff time spent in attending MHIP training and one-time start-up costs for the implementation of MHIP.
- CP shall be reimbursed for each staff person who attends MHIP training at a rate of \$36.33 per hour, not exceed 25 hours per staff person.



Claiming/Reimbursement

Training/One-Time Costs

- Specific guidelines detailing allowable one-time start-up costs are being developed and will be provided.
- Invoices for training/one-time costs must be submitted within 15 calendar days after the end of the month in which training was received and one-time expenditures were incurred.



Claiming/Reimbursement

CP shall submit all
manual/paper invoices to:

**County of Los Angeles
Department of Mental Health
550 South Vermont Avenue, 8th Floor
Los Angeles CA 90020
Attn: Provider Reimbursement Unit**



Contact Person

All questions and inquiries regarding reimbursement shall be directed to:

Sherry Trujillo, Fiscal Officer

Los Angeles County

Department of Mental Health

Accounting Division

Provider Reimbursement Unit

(213) 738-4692

TYPE OF TRAINING (Please check one of the boxes provided below):

DATE OF TRAINING: _____

11

11

11

Billing Month: _____

\$0.00

I hereby certify that all the information contained above are services and costs eligible under the terms and conditions for the reimbursement of Training and/or One-Time Funding Costs and is true and correct to the best of my knowledge. All supporting documentation will be submitted to the County along with this invoice, as specified in Exhibit B (Attachment III, Claiming and Reimbursement) of the 1115 Waiver Demonstration Project Agreement.

Date: _____

** The total amount shall not exceed \$908.25 per qualified staff for all trainings combined.

County of Los Angeles
Department of Mental Health
550 South Vermont Ave., 8th Floor
Los Angeles CA 90020
Attn: Provider Reimbursement Unit

**UTILIZATION REVIEW/
AUTHORIZATION/
DUE PROCESS**



NOTICE OF ACTION-Department of Mental Health HWLA Eligibility Denial

[Date]

[Member's Name]
[Address]
[City, State Zip]

[IS Number]
[Provider Name]

Dear [Applicant's Name]:

Thank you for applying for the Healthy Way LA (HWLA) Program.

Your HWLA application dated _____ was carefully reviewed and found to not be eligible for the HWLA program due to one of the following reasons:

- ☐ 1. You do not reside in Los Angeles County.
- ☐ 2. You are not 19 to 64 years old
- ☐ 3. You are pregnant
- ☐ 4. You are not a United States Citizen/National or Legal Permanent Resident for 5 or more years
- ☐ 5. You are eligible for Medi-Cal or Healthy Families
- ☐ 6. Your income is more than 133% of the Federal Poverty Level
- ☐ 7. You are unable to provide required information; therefore, we were unable to process your application
- ☐ 8. You did not help us in our efforts to get information required for the HWLA application process, so we're unable to process your application
- ☐ 9. Other. Specify reason: _____

This denial letter will become effective 10 days from the date of this notice of action.

If your denial was for reasons in 7, 8, or 9 above, you may be able to void this denial by contacting the person named at the end of this denial letter.

If your denial was for the reasons in 2, 3, 4, 5 or 6 above you may be eligible for other benefits. See a financial screener at your Department of Mental Health Program to help with benefits establishment.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a Healthy Way LA (HWLA) applicant, you have the following appeals rights:

1. You have the right to appeal this decision. That means that if you do not agree, you can have us review the decision to see if it is correct. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of this Notice of Action letter. **It can take up to 45 days for Healthy Way LA to decide your appeal.**

To ask for an appeal, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, call TTY/TDD at (800) 735-2929. We will help you with your appeal. You can also ask for your appeal by writing or sending a fax to:

**DMH Patients' Rights
550 S. Vermont Ave.
Los Angeles, CA 90020
Fax: (213) 365-2481**

2. You have the right to speak for yourself during the appeal or to choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer, or someone else.
3. You may send written comments, documents, records, and other information about your appeal. You may also ask for a hearing where you can give the reasons why you do not agree and examine and cross examine witnesses.
4. Before and during the appeal process, you will be able to look at your case file. The case file includes our notes on your membership renewal, supporting papers or other information related to your appeal.
5. If, after we make our decision, you are still unhappy, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing after you have finished the HWLA appeal process and have received a decision letter.

If you have questions, concerns, want to give information about your appeal, or want to ask for a meeting with the person deciding your appeal, call DMH Patients' Rights at (213) 738-4949, or use TTY/TDD at (800) 735-2929.

Sincerely,

[Name of Reviewer]

[Telephone Number]

Nancy Butram
Revenue Management Division

c: DMH Patients' Rights



**NOTICE OF ACTION
About Your Mental Health Treatment Request
Denial**

[Date]

*[Member's Name]
[Address]
[City, State Zip]*

*[Treating Provider's Name]
[Address]
[City, State Zip]
[Name of Medical Home]*

HWLA Member Identification Number: *[insert number]*

RE: *[insert type of service requested]*

(Insert name of requesting provider or medical home) has decided, after reviewing the results of an assessment of your mental health condition that your mental health condition does not meet the medical necessity criteria to be eligible for HWLA specialty mental health services because:

- ☐ Your mental health diagnosis as identified by the assessment is not covered.
- ☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services.
- ☐ The specialty mental health services available are not likely to help you maintain or improve your mental health condition.
- ☐ Your mental health condition would be responsive to treatment by a physical health care provider.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH Healthy Way LA (HWLA) member, you have the following appeal rights:

1. You have the right to appeal this decision. That means that if you do not agree, you can have us review the decision. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of this Notice of Action letter. It can take up to 45 days for DMH Patients' Rights to decide your appeal.

If you think that waiting this long could put your life or health at serious risk ask for an expedited appeal. DMH Patients' Rights will decide an expedited appeal within 3 working days.

To ask for a regular or expedited appeal, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, call TTY/TDD at (800) 735-2929. We will help you with your appeal. You can also request your appeal by writing or sending a fax to:

**DMH Patients' Rights
550 S. Vermont Ave.
Los Angeles, CA 90020
Fax: (213) 365-2481**

2. You have the right to speak for yourself during the appeal or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.
3. You may send written comments, documents, records and other information about your appeal. You may also that a hearing be held in person or by telephone.
4. Except in some limited cases you will be able to review your case file before and during the appeal process.
5. If, after we make our decision, you are still not satisfied, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing only **after** you have finished the HWLA appeal process and have received a decision letter.

If you have questions, concerns, want to give information about your appeal, or want to ask for a hearing in person or on the telephone with the person deciding your appeal, call DMH Patients' Rights at (213) 738-4949, or TTY/TDD at (800) 735-2929.

This notice does not affect any other HWLA services.

Sincerely,

(Name of Provider of Services or CAU Reviewer)

c: DMH Patients' Rights



NOTICE OF ACTION
About Your Mental Health Treatment Request
Terminate/Suspend/Reduce

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]
[Name of Provider/Clinic/CAU]

HWLA Member Identification Number: *[insert number]*
DMH IS Number: *[insert number]*

RE: *[insert type of service terminated, suspended or reduced]*

We have previously approved *(insert type of service that was approved)*.
However, we can no longer approve this treatment because *(Insert a clear and concise explanation of the reasons for the decision; the program requirements that support the action; a description of the criteria or guidelines used)*.

Approval for your treatment will end on *(insert advance date to be at least 12 calendar days from date of letter)*

NOTE: If you cannot read or understand this letter, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH Healthy Way LA (HWLA) member, you have the following appeal rights:

1. You have the right to appeal this decision. That means that if you do not agree, you can have us review the decision. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of this Notice of Action letter. It can take up to 45 days for DMH Patients' Rights Office to decide your appeal.

If you think that waiting this long could put your life or health at serious risk ask for an expedited appeal. DMH Patients' Rights will decide an expedited appeal within 3 working days.

If you want to continue this treatment while waiting for a decision on your appeal, you must ask for the appeal within 10 days from the date of this letter.

Your services will continue if:

- 1) You ask for your appeal within 10 days of the date of this letter;
- 2) The services were ordered by a mental health provider.
- 3) The original period of approved services has not ended; and
- 4) You ask to continue the treatment while the appeal is pending.

If you lose the appeal you may have to pay for the cost of the services that you received while the appeal was pending.

To ask for a regular or expedited appeal, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, call TTY/TDD at (800) 735-2929. We will help you with your appeal. You can also request for your appeal by writing or sending a fax to:

**DMH Patients' Rights
550 S. Vermont Ave.
Los Angeles, CA 90020
Fax: (213) 365-2481**

2. You have the right to speak for yourself during the appeal or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.
3. You may send written comments, documents, records and other information about your appeal. You may also ask that a hearing be held in person or by telephone.
4. Except in some limited cases you will be able to review your case file before and during the appeal process.
5. If, after we make our decision, you are still not satisfied, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing only **after** you have finished the HWLA appeal process and have received a decision letter.

If you have questions, concerns, want to give information about your appeal, or want to ask for a hearing in person or on the telephone with the person deciding your appeal, call the DMH Patients' Rights at (213) 738-4949, or use TTY/TDD at (800) 735-2929.

This notice does not affect any other HWLA services.

Sincerely,

(Name of Provider of Services or CAU Reviewer)

c: DMH Patients' Rights

GRIEVANCE FORM Healthy Way LA

Note: If you cannot read or understand this form, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

MEMBER INFORMATION

Member Name (Last)	(First)	Birth Date:	Mo.	Day	Yr.	HWLA Member ID #
						DMH IS #:
Address (Street)	(City)	(State)				(ZIP Code)
Telephone (Home)	(Cell)					(Alternate)
Name of person completing this form, if different from member name					(Daytime Telephone)	

Where did the problem occur? (Name of Hospital, Provider's Office, Clinic or Pharmacy)	Date of Incident:	Mo.	Day	Yr.
--	-------------------	-----	-----	-----

Please describe what happened as specifically as possible: Include the order in which things happened and how you were affected. **For additional space use page 2 of this form or add another piece of paper.**

What action or result are you asking for?

I understand that the Department of Mental Health Patients' Rights will contact me within sixty (60) days to give me a decision.

Signature of member/member's representative

Date:

GRIEVANCE FORM/Healthy Way LA

Describe What Happened as Specifically as Possible:

PLEASE RETURN THIS FORM TO THE DEPARTMENT OF MENTAL HEALTH PATIENTS' RIGHTS BY DOING ONE OF THE FOLLOWING:

- Fax it to the Department of Mental Health Patients' Rights at (213) 365-2481
- Return the form in person to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020
- Mail it to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020

INTERNAL USE ONLY				
1. DMH Provider (Directly Operated, LE, PPP/FQHC):				
2. HWLA Member ID#:				
3. DMH IS#:				
4. Grievance Code:				
5. Grievance Received:	In Person <input type="checkbox"/>	By Phone <input type="checkbox"/>	By Mail <input type="checkbox"/>	By Fax <input type="checkbox"/>
Grievance Received By:		Time:	Date:	



GRIEVANCE RESOLUTION LETTER Healthy Way LA

[Date]

[Member's Name]

[Address]

[City, State, Zip]

HWLA Member Identification Number: *[insert number]*

DMH IS Number: *[insert number]*

Provider/Clinic: *[insert name of provider]*

RE: NAME

Dear Addressee:

A decision has been made regarding your grievance of <date at bottom of grievance form, concerning <state reason> on <date of incident>.

Department of Mental Health (DMH) Patients' Rights has worked with <name of facility and/or title of person> to investigate your grievance.

<state findings>

<state conclusion and result, i.e. this is what will happen>

We value you as a DMH HWLA member.

Your concerns help us to monitor the services provided and to improve care for all of our members.

If you have questions or concerns, please contact DMH Patients' Rights at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

(insert name)

DMH Patients' Rights Advocate



APPEAL REQUEST FORM Healthy Way LA
(An appeal may only be made after receiving a Notice of Action)

Note: If you cannot read or understand this form, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

MEMBER INFORMATION

Member Name (Last)	(First)	Birth Date:	Mo.	Day	Yr.	HWLA Member ID #
Address (Street)		(City)	(State)			DMH IS # (ZIP Code)
Telephone (Home)	(Cell)					(Alternate)
Name of person completing form, if different from member name					(Daytime Telephone)	

Please attach a copy of your Notice of Action	Notice of Action Date:
Name of Provider/Clinic:	
Please tell us why you do not agree with the decision about your mental health services. You may attach any papers that support your appeal. For additional space use page 2 of this form or add another piece of paper.	
Answer this question only if you had a service or treatment that has been stopped or limited Are you asking for the stopped or limited services to keep going during the appeal? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If you think your situation is urgent, and waiting 45 days will put your life or health at serious risk, tell us what may happen without a quick decision:	
Does your Provider agree that this situation is urgent? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I understand that the Department of Mental Health Patients' Rights will contact me within forty-five (45) days to give me a decision on my appeal.	
Signature of member/member's representative	Date

APPEAL REQUEST FORM/Healthy Way LA

Please tell us why you do not agree with the decision about your mental health services. **For additional space add another piece of paper.**

Deleted: ¶

PLEASE RETURN THIS FORM TO THE DEPARTMENT OF MENTAL HEALTH PATIENTS' RIGHTS BY DOING ONE OF THE FOLLOWING:

- Fax it to the Department of Mental Health Patients' Rights at (213) 365-2481
- Return form in person to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020
- Mail it to Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020

INTERNAL USE ONLY

(Complete only if a Potential Expedited Appeal)

Definition: An expedited appeal is one that involves an issue that could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Member was told that the expedited appeal would be decided within three working days of its receipt?

Yes ☐ No ☐

Member was told to provide supporting documentation by the next working day?

Yes ☐ No ☐

Date Appeal Acknowledgement Given:

1. DMH Provider (Directly Operated, LE, PPP/FQHC, CAU:

2. HWLA Member ID:

3. DMH IS #:

4. Appeal received : In Person ☐ By Phone ☐ By Mail ☐ By Fax ☐

Appeal Received By:

Time:

Date:



APPEAL ACKNOWLEDGEMENT LETTER

[Date]

[Member's Name]

[Address]

[City, State, Zip]

HWLA Member Identification Number: *[insert number]*

Dear [Member]:

We received your appeal on *[insert date]*. Thank you for letting us know about your request for a review of the Notice of Action.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH HWLA member you have the following rights:

1. You have the right to speak for yourself during the appeal or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.
2. You may send written comments, documents, records and other information about your appeal. **You should send in those papers within 10 days the date of this letter. If you do not send them by that time, we may not consider your papers in making our decision.**
3. You may also ask for a hearing in person or by telephone with the person deciding the appeal where you can give your reasons why you disagree and examine and cross examine witnesses. If you want a hearing, you must call within **10 days** of the date of this letter.
4. Before and during the appeal process you have the right to look at the case file (except for certain mental health professional notes in some limited cases). The case file includes medical records, other written notes, documents or other information related to your appeal.
5. If, after we make our decision, you are still unhappy, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing **after** you have finished the HWLA appeal process and have received an appeal decision letter.

If you have questions, or want to request a hearing, call DMH Patients' Rights at (213) 738-4949 or use TTY/ TDD at (800) 735-2929. You may also give information about your appeal by mailing or faxing it to:

HWLA Member Services
1100 Corporate Center Drive, Suite 100
Monterey Park, CA 91754
Fax: (626) 308-1582

We will investigate your appeal and will contact you if we need more information. A letter with our decision will be mailed to you within 45 days from the date we received your appeal.

Again, thank you for letting us know about your concerns. We value you as a HWLA member and we will make every effort to meet your health care needs.

Sincerely,

[Insert name]

HWLA Grievance and Appeal Coordinator
Health Way LA Program

cc: Medical Home



APPEAL ACKNOWLEDGEMENT LETTER/Healthy Way LA Late Request

[Date]

[Member's Name]

[Address]

[City, State, Zip]

HwLA Member Identification Number: [insert number]

DMH IS Number: [insert number]

Provider/Clinic/CAU: [insert name of provider]

Dear [addressee]:

You asked for an appeal from the Notice of Action dated (insert NOA date) regarding (describe appeal). The appeal was received on (insert date), which is more than sixty (60) days after the date on the Notice of Action.

Your appeal is being denied because you did not ask for it within the appeal time limits.

NOTE: If you cannot read or understand this letter, call Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

If you do not agree with this decision, you have the following appeal rights:

1. You can ask for a State Fair Hearing. You must ask for a State Fair Hearing within **90 days** from the date on this letter.

To request a State Fair Hearing, call (800) 952-5253. If you have trouble hearing or speaking, you can call TTY/TDD at (800) 952-8349. You may also ask for your appeal by writing to:

**State Hearings Division
California Department of Social Services
PO Box 944243, Mail Station 1937
Sacramento, CA 94244-2430**

2. Please provide a copy of your request for a State Fair Hearing if you file one.

This notice does not affect any other HWLA services.

Please call Patients' Rights at (213) 738-4949, or use TTY/TDD at (800) 735-2929 if you have any questions.

Sincerely,

(insert name)

DMH Patients' Rights Advocate

c: Requesting Provider
CAU

10/18/2011



**NOTICE
About Your Mental Health Treatment Request
Decision Delay**

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]
[Name of Provider/Clinic/CAU]

HWLA Member Number: *[insert number]*
DMH IS Number: *[insert number]*

RE: *[insert type of service requested]*

(Mental Health Provider or the CAU) has not processed your

- ☐ grievance ☐ appeal ☐ expedited appeal on time
☐ request for mental health services ☐ request for authorization for additional services

Our records show you made your request on:

You requested that _____

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

A decision will be made as soon as possible but no later than: ***[Insert the Date; Not to Exceed More than 28 Calendar Days From Receipt of Original Request]***

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH Healthy Way LA (HWLA) member, you have the following rights:

1. You have the right to file a grievance if you do not think this delay is proper. If you want to file a grievance, you must ask for the grievance within **60 days** from the date you get this letter. It can take up to 60 days for DMH Patients' Rights to decide your grievance.

To file a grievance, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, call TTY/TDD at (800) 735-2929. We will help you with your grievance. You may also file your grievance by fax or by writing to:

**DMH Patients' Rights
550 S. Vermont Ave.
Los Angeles, CA 90020
Fax: (213) 365-2481**

2. You have the right to speak for yourself or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.

This notice does not affect any other HWLA services.

Sincerely,

(Name of Provider/Clinic/CAU)

c: DMH Patients' Rights



NOTICE

[Date]

[Member's Name]

[Address]

[City, State Zip]

HWLA Member ID #: [insert number]

[IS Number]

[Provider Name]

RE: Request for an Expedited Appeal

Dear [Member's Name]:

We received your request for an Expedited Appeal for a review of a Notice of Action on [insert date].

Your request for an Expedited Appeal is denied because *(Insert a clear and concise explanation of the reasons for the decision; and include the program requirements that support the action and a description of the criteria or guidelines used)*.

Your appeal of the Notice of Action will go through the Standard Appeal process. This means we will investigate your appeal and will contact you if we need more information. A letter with our decision will be mailed to you within 45 days from the date we received your appeal.

Again, thank you for letting us know about your concerns. We value you as a HWLA member and we will make every effort to meet your health care needs.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

If you have questions, concerns, want to give information about your appeal, or want to ask for a meeting with the person deciding your appeal, call DMH Patients' Rights at (213) 738-4949, or use TTY/TDD at (800) 735-2929.

This notice does not affect any other HWLA services.

Sincerely,

(Name of DMH Patients' Rights Advocate)

c: Requesting Provider/Clinic/CAU
Healthy Way LA Member Services



APPEAL DECISION LETTER Healthy Way LA OVERTURN DECISION

Date:

Name: *(Insert Member Name or Representative):*

Member's Name:

Address:

City, State, Zip

Provider/Clinic/CAU:

Dear *(Insert Member Name or Representative):*

A decision has been made about your appeal of *(describe appeal)*.

After careful review and investigation, our reviewer does not agree with the original decision.

Your request has now been approved. Authorization for *(insert service)* is effective from *(insert effective dates)*. Please call *(insert provider/clinic name and telephone number)* to make an appointment for this service.

If you have any questions, please call DMH Patients' Rights at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

(Name of Patients' Rights Advocate)

c: Requesting Provider/Clinic/CAU



**DEPARTMENT OF MENTAL HEALTH
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APPROVED BY:		ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S)
		DRAFT	DMH

1.0 PURPOSE:

- 1.1 To delineate the grievance process for Department of Mental Health (DMH) Healthy Way LA (HWLA) members, in accordance with the principles set forth in DMH/DHS Healthcare Collaboration Program Policy No. ____ .

2.0 POLICY:

- 2.1 DMH HWLA provides a mechanism to ensure that a thorough and consistent process for addressing DMH HWLA members' grievances is available and accessible to all members. All grievances relating to the mental health benefit must be processed through DMH Patients' Rights.

3.0 DEFINITIONS:

- 3.1 DMH HWLA Member: An individual enrolled in the HWLA Program and requesting/receiving DMH services.
- 3.2 Grievance: An expression of dissatisfaction about any matter other than an action.
- 3.3 Appeal: A request for review of an "Action."
- 3.4 "Action" any of the following:
1. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI) known to LA County as HWLA.
 2. A denial or limited authorization of a requested service, including the type or level of service.
 3. A reduction, suspension, or termination of a previously authorized service.
 4. A failure to provide services in a timely manner.
 5. A failure by DMH HWLA to act within the timeframes established for grievance and appeals.



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- 3.5 *Delinquent*: Refers to a grievance that is not resolved within sixty (60) days.
- 3.6 *Resolved*: Means that DMH HWLA has reached a final conclusion with respect to the member's submitted grievance.
- 3.7 *Day*: Unless otherwise specified, "day" means calendar day.

4.0 IMPLEMENTATION REQUIREMENTS & SUMMARY PROCEDURES:

- 4.1 The member will be provided with detailed instructions and information regarding how to file a grievance. Grievance forms will be available through DMH Patients' Rights and service sites. Grievance forms will be available to any member wishing to file a grievance.
- 4.2 FILING A GRIEVANCE – DMH HWLA members may file a grievance directly with DMH Patients' Rights.
 - 4.2.1 DMH HWLA members may register grievances by telephone, in writing, fax, or in person. Members may submit a grievance in a written note/letter, or by completing the grievance form.
 - 4.2.2 If protected health information (PHI) will be needed to investigate and resolve the grievance and the member's grievance involves persons not part of DMH's workforce, then an authorization for the disclosure of PHI must be attained.
 - 4.2.3 DMH HWLA members are allowed sixty (60) days from the date of the incident or event to file a grievance.
 - 4.2.4 When the member wishes to file a grievance, the DMH Patients' Rights Office will document the grievance on the Grievance Log and, provide the member with a grievance form, assist the member in completing the form if appropriate, and explain the grievance procedure.
 - 4.2.5 At the time of filing the grievance, the member may present facts, evidence, or law in support of his or her position.
- 4.3 DMH clinics/providers shall report all member grievances that they receive by forwarding the completed grievance form or other writing that expresses



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- 4.4 the grievance to DMH Patients' Rights within twenty-four (24) hours of its receipt.
- 4.5 RECEIPT OF GRIEVANCE – Subsequent to receipt of the written grievance the DMH Patients' Rights Office is responsible for recording all grievances in the Grievance Log and/or an electronic database. Documents received describing the member's concerns will be date-stamped upon receipt.
- 4.6 The database for each grievance shall reflect the following information:
- 4.6.1 Date and time grievance was filed by the member
 - 4.6.2 Date and time grievance was first received
 - 4.6.3 Member's name
 - 4.6.4 Member's HWLA number
 - 4.6.5 A description of the complaint or problem
 - 4.6.6 The name of the staff person receiving the grievance
 - 4.6.7 Date acknowledgement letter was sent
 - 4.6.8 The name of the staff person responsible for resolving the grievance
 - 4.6.9 A description of the action taken by DMH Patients' Rights to investigate and resolve the grievance
 - 4.6.10 Date of resolution/response to member
 - 4.6.11 Status of grievance
 - 4.6.12 The resolution of the grievance
 - 4.6.13 Whether the grievance was resolved in favor of the member
 - 4.6.14 Date of disposition
 - 4.6.15 Final status
- 4.7 CREATING A GRIEVANCE FILE – DMH Patients' Rights Office (as appropriate) will create a paper grievance case file referencing the member's name and HWLA identification number. DMH Patients' Rights Office will record the grievance using the Grievance Log and Grievance Data System.



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- 4.8 ACKNOWLEDGEMENT LETTER – DMH Patients' Rights Office will send a written acknowledgement letter in the appropriate language within seven (7) days of receipt of the grievance. Grievances received over the telephone that meet all of the following requirements are exempt from the requirement to send a separate written acknowledgement: (i) do not relate to coverage, (ii) do not involve disputes related to the medical necessity of services, and (iii) are resolved by the close of the next business day. A letter that includes both an acknowledgement and the resolution will be sent within seven (7) days of the receipt of the grievance.
- 4.9 RESOLUTION LETTER - DMH Patients' Rights will send a written resolution letter in the member's primary or preferred language, large print, or other alternative format within sixty (60) days of receipt of the grievance, with a copy to the clinic/provider. This time frame may be extended for up to 14 days if requested by the member or if DMH can show that there is a need for additional information and the delay is in the best interest of the member.
- 4.10 DELINQUENT RESOLUTION – In the event resolution can not be reached within sixty (60) days, the member shall be notified before the sixtieth day in writing by DMH Patients' Rights of the status of the grievance and shall be provided with an estimated completion date of resolution. The letter will notify the member of his/her right to request an appeal regarding the lack of timely resolution.
- 4.11 FILE CLOSURE – When DMH Patients' Rights Office sends the decision letter to the member, the grievance file will be closed and the decision recorded in the Grievance Database System.
- 4.12 NOT APPEALABLE: Members may not appeal the resolution of grievances to the State Fair Hearing process.
- 4.13 NON-DISCRIMINATION – DMH HWLA and DMH clinics/providers will not discriminate against a member (including disenrollment of the member) for filing a grievance. DMH HWLA will not discriminate against a member based on disability, or cultural/linguistic needs. DMH HWLA will ensure that



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all members have access to, and can fully participate in, the grievance process by providing assistance to members with Limited English Proficiency and/or with a visual or other communicative impairment. Such assistance will include, but is not limited to, translation and/or interpretation services in the member's preferred language related to grievance procedures, forms, and responses to grievances. Additionally, DMH HWLA will provide access to interpreters, telephone relay systems, and other devices that aid disabled individuals with communication.

4.14 REPORTING

4.14.1 DMH Patients' Rights will submit a monthly Grievance Report to the HWLA Administrative Grievance and Appeal Coordinator by the fifth (5) day of the following month. If the DMH Patients' Rights Office reports no grievances, the report will reflect the following: "No Grievance Received." Reports must be signed and dated by a representative of DMH Patients' Rights. This report can be combined with the monthly Appeals Report.

4.14.2 DMH Patients' Rights will report grievance information to regulatory agencies as required.

5.0 MONITORING MECHANISM AND ACCOUNTABILITY:

5.1 The DMH Patients' Rights Director or Designee will monitor the grievance process. Periodic evaluations of the process will be performed to determine effectiveness. Modifications will be made where necessary to ensure adequate and timely response to members. The DMH Patients' Rights Director or Designee will oversee the member grievance process to ensure compliance with the State's required time frames.

5.2 Each DMH clinic/provider shall designate a facility liaison to coordinate grievance procedures with DMH Patients' Rights.

5.3 Staff from DMH Patients' Rights will collaborate to identify a monitoring mechanism and assist with site visits to the DMH clinic/provider to ensure that the member grievance processes adhere to all regulatory and contractual requirements.



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5.4 DMH Patients' Rights staff conducts grievance training to internal and external personnel. This includes a section on preventing discrimination against members.

6.0 PRIVACY AND SECURITY:

6.1 Member grievance data is secure and individual member information is not shared with any other entity not involved in the grievance investigation.

7.0 AUTHORITY:

- 7.1 Title 42, Code of Federal Regulations ("CFR"), Section 438.404
- 7.2 Title 42, Code of Federal Regulations ("CFR"), Section 438.406
- 7.3 Title 42, Code of Federal Regulations ("CFR"), Section 438.408
- 7.4 Title 42, Code of Federal Regulations ("CFR"), Section 438.410
- 7.5 Title 42, Code of Federal Regulations ("CFR"), Section 438.420
- 7.6 Title 42, Code of Federal Regulations ("CFR"), Section 438.424
- 7.7 Department of Health Care Services, California Bridge to Reform Waiver Hearings and Appeals Process for Low Income Health Programs (LIHP)

8.0 PROCEDURE:

8.1 Refer to the attached DMH HWLA Grievance & Appeal Flow Charts and DMH HWLA Provider Manual.

Unit Manager: _____ **Date:** _____
Name/Title:

Approved/ Division Manager: _____ **Date:** _____
Name/Title:

Approved/Executive Officer: _____ **Date:** _____
Name/Title:



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		DRAFT	DMH

1.0 PURPOSE:

- 1.1 To provide a full and fair process for members to appeal a decision they find unacceptable regarding mental health services.
- 1.2 To delineate the process for investigating and responding to DMH Healthy Way LA (HWLA) members' appeals regarding mental health services.

2.0 POLICY:

- 2.1 DMH HWLA provides a process for thorough, appropriate and timely resolution of member appeals in accordance with state and federal rules.

3.0 DEFINITIONS:

- 3.1 Member: An individual enrolled in the HWLA Program and requesting/receiving DMH Services.
- 3.2 Appeal: A request from a member for review of an "Action."
 - 3.2.1 Standard Appeal: A formal appeal process whereby a member exercises his or her right to obtain a review of an Action within the standard period of time. Standard appeals are resolved within forty-five (45) days of receipt of the appeal.
 - 3.2.2 Expedited Appeal: A formal appeal process whereby the appeal and the final determination of that appeal are made and notice provided to the member within a timeframe not to exceed three (3) business days from receipt of the appeal. Appeals are expedited when waiting for a standard decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.



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3.3 *“Action”* any of the following:

1. A denial or limited authorization of a requested service, including the type or level of service;
2. A reduction, suspension, or termination of a previously authorized service;
3. A failure to provide services in a timely manner;
4. A failure of DMH HWLA to act within the timeframes established for resolving grievances and appeals.

3.4 *Grievance*: An expression of dissatisfaction about a matter other than an Action.

3.5 *State Fair Hearing*: An administrative hearing process carried out by California Department of Social Services (DSS) to resolve disputes regarding an Action.

3.6 *Day*: Unless otherwise specified, “day” means calendar day.

3.7 *Hearing*: A telephone or in person process in which information is presented to the decision maker. A hearing includes the ability to examine or cross examine witnesses.

4.0 IMPLEMENTATION REQUIREMENTS & SUMMARY PROCEDURES:

4.1 DMH HWLA members will be provided with detailed information about their appeal rights and instructions on how to file an appeal of an Action. Appeal forms will be available at the clinic/provider sites and DMH Patients’ Rights Office. Appeal forms will be provided to any member wishing to file an appeal.

4.2 *FILING AN APPEAL*– DMH HWLA members, a designated representative, or a provider acting on the member’s behalf, may file an appeal with DMH Patients’ Rights by telephone, in writing, fax, or in person.

4.2.1 When the member expresses a wish to file an appeal, DMH Patients’ Rights will explain the appeal procedure and assist the member in completing the form if applicable.

4.2.2 Appeal forms are available at the clinic/provider site and the DMH Patients’ Rights office. Appeal forms will be provided to any member wishing to file an appeal.



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Members may submit an appeal verbally, in a written note/letter, or by completing an appeal form. Verbal appeals must be confirmed in writing.

- 4.2.3 A member may designate a representative to assist her/him in the appeal.
- 4.2.4 HWLA members must file an appeal within sixty (60) days of the date of the Notice of Action.
- 4.2.5 When the member files an appeal, DMH Patients' Rights will document the appeal on the Appeal Log.
- 4.2.6 At the time of filing the appeal, the member may present facts, evidence or law in support of his or her position.

4.3 RECEIPT OF APPEAL – Subsequent to receipt of the written appeal, the DMH Patients' Rights Office is responsible for recording all appeals in the Appeal Log and/or an electronic database. Documents received describing the member's concerns will be date-stamped upon receipt.

4.4 The database for each appeal shall reflect the following information:

- 4.4.1 Date and time appeal was filed by the member
- 4.4.2 Date and time appeal was received
- 4.4.3 Member's name
- 4.4.4 Member's HWLA identification number
- 4.4.5 A description of the reasons for appeal



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- 4.4.6 The name of the staff person receiving the appeal
- 4.4.7 Date acknowledgement letter was sent
- 4.4.8 The name of the staff person responsible for resolving the appeal
- 4.4.9 A description of the actions taken by DMH Patients' Rights to investigate the appeal
- 4.4.10 Decision made
- 4.4.11 Date of decision
- 4.4.12 Whether the appeal was decided in favor of the member
- 4.4.13 Date decision letter was sent
- 4.4.14 Final date by which a request for State Fair Hearing must be requested
- 4.4.15 Final status

4.5 CREATING AN APPEAL FILE

- 4.5.1 DMH Patients' Rights will create a paper appeal case file referencing the member's name and identification number. The DMH Patients' Rights will record the appeal using the Appeal Log and Appeal Data System.

4.6 PROCESSING STANDARD APPEALS

- 4.6.1 Members must file an appeal within sixty (60) days of the date of the Notice of Action letter. Appeals filed outside this period will be summarily denied.
- 4.6.2 DMH Patients' Rights will send written acknowledgement of the appeal to the member within seven (7) days. Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by DMH Patients' Rights unless the member or provider requests an expedited decision.
- 4.6.3 DMH Patients' Rights will investigate the appeal and findings and hearings will occur as provided for in sections 4.12, 4.13, and 4.14 below and DMH Patients' Rights will render a decision within forty-five (45) days from DMH HWLA's receipt of the appeal.



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4.7 EXTENDING STANDARD APPEAL TIMEFRAMES

The forty-five (45) day timeframe may be extended by an additional fourteen (14) days if:

4.7.1 The member requests the extension; or

4.7.2 DMH HWLA needs additional information and the delay is in the best interest of the member. In this case, DMH HWLA will provide the member with written notification of the reason for the delay before forty-five (45) days have expired.

4.8 PROCESSING EXPEDITED APPEALS

4.8.1 The member or provider may request an expedited review of an appeal if waiting forty-five (45) days for a standard appeal determination could seriously jeopardize the member's life or well-being.

4.8.2 The DMH Patients' Rights will review the expedited appeal, render a decision, and assure that notice to the member is given within three (3) business days of the member's or provider's request.

4.9 EXTENDING EXPEDITED APPEAL TIMEFRAMES

The three (3) business day timeframe may be extended by up to fourteen (14) calendar days if:

4.9.1 The member requests an extension; or

4.9.2 DMH HWLA needs additional information and the delay is in the best interest of the member. In this case, DMH HWLA will provide the member with written notification of the reason for the delay before the three (3) business days have expired.

4.10 DENIAL OF REQUESTS FOR EXPEDITED APPEAL

4.10.1 Before expediting an appeal, the DMH Patients' Rights reviews the case for evidence of imminent and serious threat to a member's health and well-being.

4.10.2 If the case does not meet the expedited appeal criteria, as determined by DMH Patients' Rights, DMH Patients' Rights will promptly give oral notification of the denial of the request for expedited appeal to the member, the clinic/provider and DMH.



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4.10.3 DMH Patients' Rights will send written notice to the member within two (2) days. The notice will include a right to grieve the determination not to expedite the appeal.

4.10.4 The appeal is then transferred to the timeframe for standard appeal processing – forty-five (45) days from receipt of request.

4.11 CASE REVIEW

4.11.1 DMH Patients' Rights staff will investigate and will review the information and paperwork, supporting documents, and request records as appropriate that were used to make the decision. DMH Patients' Rights will review the paperwork and supporting documents and request medical records as appropriate.

4.11.2 DMH Patients' Rights will investigate all identified appeal issues and review relevant records, other written notes, documents, and other information. This investigation will include the review of any facts, evidence, or legal arguments provided by the member at the time of filing the appeal or later.

4.11.3 Members will be informed in the appeal acknowledgement letter that they should submit evidence to DMH Patients' Rights within ten (10) days of the date on the letter. Materials received from the member after ten (10) days have passed from the date of the appeal acknowledgement letter may, but do not have to, be considered in making the final decision.

4.12 APPEAL REVIEWERS

4.12.1 The individual making a decision on the appeal must not be involved in any previous level of review or decision.

4.12.2 A physician or other mental health care professional with the appropriate clinical expertise in treating the member's condition must review the following:

4.12.2.1 An appeal of a denial based on medical necessity



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4.12.2.2 An appeal regarding denial of expedited resolution of an appeal

4.12.2.3 An appeal that involves clinical issues

4.13 APPEAL HEARING PROCESS

4.13.1 Members and their representatives have the opportunity, before and during the appeals process, to examine the member's case file, including records (except in certain limited situations), and any other documents under consideration in the appeal.

4.13.2 Members are informed in the appeal acknowledgement letter that they should request a hearing from DMH Patients' Rights within ten (10) days of the date on the appeal acknowledgement letter. Hearings will only occur if requested by the member within the appropriate timeframe.

4.13.3 Appeal hearings will take place during normal business hours.

4.13.4 A list will be established of people to be on appeal panels.

4.13.5 The original decision maker and the decision maker on appeal must be present during the hearing.

4.13.6 An internal scheduling process will be developed to identify times that panel members are available. Two time options will be made available to the member who requested the appeal.

4.13.7 One hour will be scheduled for the hearing. The hearing will take place no earlier than twenty (20) days and no later than thirty-five (35) days after the appeal was filed.

4.13.8 The hearing may take place in person or on the telephone. Members and their representative will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses.

4.13.9 During the hearing a sign-in sheet will be circulated. Minutes will be taken and will include the names of participants, name of person representing member (as appropriate), and a short summary of the information provided. The hearing will not be recorded by a court reporter, but may be taped for the convenience of the decision maker at his or her discretion.



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4.14 FORMAL NOTICE OF APPEAL DECISION

DMH HWLA will provide the member with a written notice of the appeal decision (decision letter). The appeal decision letter must include the following elements, when applicable:

- 4.14.1 The results of the decision process and the date it was completed.
- 4.14.2 The specific reasons for the appeal decision, in easily understandable language.
- 4.14.3 At the discretion of the reviewer, a reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
- 4.14.4 A description of the next level of appeal, if the appeal is not resolved wholly in favor of the member, to include the following:
 - 4.14.4.1 Current information and process for requesting a State Fair Hearing to the Department of Social Services, including the time-frames required for submission.
 - 4.14.4.2 The right to request to receive the contested benefits while the hearing is pending, and how to make that request.
 - 4.14.4.3 That the member may be held liable for the cost of the contested benefits if the hearing decision upholds DMH HWLA's appeal decision.
 - 4.14.4.4 A request that the member notify DMH Patients' Rights if he or she requests a State Fair Hearing.

4.15 CONTINUATION OF COVERED SERVICE BENEFITS

4.15.1 DMH HWLA will continue to provide the covered but contested service benefits for members during the internal appeal process or the State Fair Hearing (SFH) process if all the following conditions are met:

- 4.15.1.1 the member or provider files the appeal within ten (10) days from the date of mailing the Notice of Action, which is assumed to be the date on the Notice of Action;
- 4.15.1.2 the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- 4.15.1.3 the services were ordered by a DMH HWLA provider;



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4.15.1.4 the period covered by the original authorization has not expired; and

4.15.1.5 the member requests an extension of benefits.

4.15.2 The contested service benefits will continue to be provided until one of the following occurs:

4.15.2.1 the member withdraws the appeal;

4.15.2.2 ten (10) days pass after DMH Patients' Rights mails the appeal decision letter; unless the member requests, within ten (10) days of receiving the Decision letter, a SFH with continuation of benefits;

4.15.2.3 benefits were provided pending the SFH and a SFH decision is reached which is adverse to the member;

4.15.2.4 the time period or service limits of the previous authorization has been met.

4.16 STATE FAIR HEARING PROCESS

4.16.1 Exhaustion of the internal appeal process is required of a member prior to filing a request for a State Fair Hearing (SFH) to appeal an Action.

4.16.1.1 A SFH must be requested within ninety (90) days of the date of the Decision Letter of the internal appeal of an Action.

4.16.1.2 DMH HWLA will be a party to the SFH.

4.17 NON-DISCRIMINATION

DMH HWLA and DMH clinics/providers will not discriminate against a member (including disenrollment of the member) for filing an appeal. DMH HWLA will not discriminate against a member based on disability, or cultural/linguistic needs. DMH HWLA will ensure that all members have access to and can fully participate in the appeal process by providing assistance to members with Limited English Proficiency and/or with a visual or other communicative impairment. Such assistance will include, but is not limited to, translation and/or interpretation services in the member's preferred language related to appeal procedures, forms, and responses to appeals. Additionally, DMH HWLA will provide access to interpreters, telephone relay systems, and other devices that aid persons with disabilities with communication.



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4.18 REPORTING

4.18.1 DMH Patients' Rights will submit a monthly Appeal Report to the HWLA Administrative Grievance and Appeal Coordinator by the fifth (5) day of the following month. The reports can be combined with the monthly Grievance Reports. If DMH Patients' Rights reports no appeals, the report will reflect the following: "No Appeals Received." Reports must be signed and dated by a representative of DMH Patients' Rights.

4.18.2 DMH Patients' Rights will report appeal information to regulatory agencies as required.

5.0 MONITORING MECHANISM AND ACCOUNTABILITY:

5.1 The DMH Patients' Rights Director or Designee will monitor the appeal process. Periodic evaluations of the process will be performed to determine effectiveness. Modifications will be made where necessary to ensure adequate and timely response to members. The DMH Patients' Rights Director or Designee will oversee the member appeal process to ensure compliance with the State's required time frames.

5.2 Each DMH clinic/provider shall designate a facility liaison to coordinate appeal procedures with DMH Patients' Rights.

5.3 All DMH clinics, providers, and staff are required to cooperate with DMH Patients' Rights in the member appeal process and to comply with all final determinations reached through the DMH HWLA appeals procedure and SFH.

5.4 DMH Patients' Rights staff conducts appeal training to internal and external personnel. This includes a section on preventing discrimination against members.

6.0 PRIVACY AND SECURITY:

6.1 Member appeal data is secure and individual member information is not shared with any other entity not involved in the appeal process.



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7.0 AUTHORITY:

- 7.1 Title 42, Code of Federal Regulations, Sections 438.400 and following
- 7.2 Centers for Medicare & Medicaid Services Special Terms and Conditions 11-W-001939/9 California Bridge to Reform Demonstration, California Health and Human Services Agency

8.0 SOURCES AND REFERENCE:

- 8.1 Department of Health Care Services, California Bridge to Reform Waiver Hearings and Appeals Process for Low Income Health Programs – DHCS Revised Draft 04/26/2011
- 8.2 DMH HWLA Member Grievance Process Policy & Procedure Number 0001

Unit Manager: _____ Date _____

Name:

Title:

Approved: _____ Date _____

Name:

Title:

Approved: _____ Date _____

Name:

Title:

DMH DIRECTORY

Los Angeles County – Department of Mental Health Resource Directory

Healthy Way L.A. & DMH/DHS Collaborative Programs 550 S. Vermont Avenue, 12th Floor Los Angeles, CA 90020	
Clinical Operations Kathleen Kerrigan, RN, LCSW (213) 738-3111 kkerrigan@dmh.lacounty.gov <ul style="list-style-type: none"> • DHS Co-located Sites • MHIP Model – Training, Technical Assistance, QA/QI • Operational Agreements between DMH Directly-operated and Community Partners • Tier 2 & 3 Services at Primary Health (DHS) Sites 	Administrative Operations Lisa Wicker, LCSW (213) 738-2297 lawicker@dmh.lacounty.gov <ul style="list-style-type: none"> • Contracts • Budget, Fiscal, Claiming Reports, Monitoring • Manual Invoices – Training & One-time Costs • IT/IS, PFARs • Referral/Enrollment Tracking

Adult Navigators		
Service Area 1 Miesha Worthey	(661) 223-3820	mworthey@dmh.lacounty.gov
Service Area 2 Darrell Scholte	(818) 610-6705	dscholte@dmh.lacounty.gov
Service Area 3 Eugene Marquez	(626) 471-6535	emarquez@dmh.lacounty.gov
Service Area 4 Christine Hubbard Anna Barrientos	(323) 671-2621 (323) 671-2617	chubbard@dmh.lacounty.gov abarrientos@dmh.lacounty.gov
Service Area 5 Joseph (Sandy) Mills	(310) 482-6619	jmills@dmh.lacounty.gov
Service Area 6 Margarita (Maggie) Cabrera	(323) 290-5287	mcabrera@dmh.lacounty.gov
Service Area 7 Terelui (Tere) Antoni	(213) 738-6150	tantoni@dmh.lacounty.gov
Service Area 8 Alicia (Lisa) Powell	(562) 435-2287	apowell@dmh.lacounty.gov

Chief Information Office Bureau (CIOB) 695 S. Vermont Avenue Los Angeles, CA 90020 (213) 351-1335 Help Desk
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Contracts Administration 550 S. Vermont Avenue, 5th Floor Los Angeles, CA 90020		
Jennifer Koai	(213) 738-4035	jkoai@dmh.lacounty.gov

Financial Services Bureau 550 S. Vermont Avenue, 8th Floor Los Angeles, CA 90020		
All questions regarding reimbursement to: Sherry Trujillo, Fiscal Officer I	(213) 738-4692	strujillo@dmh.lacounty.gov

Managed Care Division/Utilization Review Authorizations & Due Process 550 S. Vermont Avenue, 7th Floor Los Angeles, CA 90020		
Alan Lert, PhD Lead Person	(213) 739-7308	alert@dmh.lacounty.gov
Patricia Claybrook, RN Due Process/Appeals	(213) 738-6151	pclaybrook@dmh.lacounty.gov
Julie Agojo, RN Policies	(213) 738-2431	jagojo@dmh.lacounty.gov

Patients' Rights Office 550 S. Vermont Avenue, Suite 608 Los Angeles, CA 90020 (213) 738-2524		
Rashied Jibri, Supervisor	(213) 738-2601	rjibri@dmh.lacounty.gov
Rolinda Shaw, Supervisor	(213) 738-2524	rshaw@dmh.lacounty.gov
Sylvia Guerrero, MH Analyst I Due Process/Appeals	(213) 738-4124	sguerrero@dmh.lacounty.gov

Quality Assurance Division 550 S. Vermont Avenue, Suite 502 Los Angeles, CA 90020		
Rosalie Esquibel Clinical Records Director	(213) 739-6335	resquibel@dmh.lacounty.gov
Jennifer Hallman, LCSW Documentation	(213) 738-3770	jhallman@dmh.lacounty.gov
Clinical Forms		http://dmh.lacounty.gov/Forms.asp
Organizational Provider's Manual		http://dmh.lacounty.gov/Agency_Admin.asp
IS Codes Manual		http://dmh.lacounty.gov/hipaa/index.html

Revenue Management		
RMD Hotline	(213) 480-3444	revenuemanagement@dmh.lacounty.gov

Service Area District Chiefs		
Service Area 1 2323-A East Palmdale Blvd. Palmdale, CA 93550 JoEllen Perkins, LCSW	(661) 223-3827	jperkins@dmh.lacounty.gov
Service Area 2 Children's System of Care Superior Court Building 600 S. Commonwealth Ave. 15 th Fl. Los Angeles, CA 90005 Eva Carrera, LCSW	(213) 739-5538	ecarrera@dmh.lacounty.gov
West Valley Wellness Center 6800 Owensmouth Ave #160 Canoga Park, CA 91304 Eva Carrera, LCSW (interim)	(213) 739-5538	ecarrera@dmh.lacounty.gov
Service Area 3 Superior Court Building 600 S. Commonwealth Ave. 6 th Fl. Los Angeles, CA 90005 Alfredo Larios, LCSW	(213) 739-5455	alarios@dmh.lacounty.gov
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